DOCUMENT RESUME

ED 149 226 CG 012 096

TITLE Medicine and Aging: An Assessment of Opportunities and Neglect. Hearing Before the Special Committee on Aging, United States Senate, Ninety-fourth Congress, Second Session, New York, N.Y.

PUB DATE 16 Oct 76

NOTE 110p.; Not available in hard copy due to marginal legibility and small type

AVAILABLE FROM Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402

EDRS PRICE MF-$0.83 Plus Postage. HC Not Available from EDRS.

DESCRIPTORS *Age; Federal Government; *Geriatrics; Government Publications; *Health; *Medical Education; *Nursing Homes; *Older Adults; Personal Care Homes

IDENTIFIERS *Congressional Hearings

ABSTRACT

This booklet presents a complete transcript of the hearings on medicine and aging of the Senate Committee on Aging. Testimony from a number of experts in gerontology is presented. A wide range of topics is dealt with, including social attitudes toward aging, current medical training and practices, and the need for research about the aging process. An extensive appendix presents further statements from interested organizations and individuals. (Author/BP)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED149226

MEDICINE AND AGING: AN ASSESSMENT OF OPPORTUNITIES AND NEGLECT

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

NEW YORK, N.Y.

OCTOBER 13, 1976

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

MAY 19 1977

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

80-581 WASHINGTON : 1977

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

CG012096

SPECIAL COMMITTEE ON AGING

FRANK CHURCH, Idaho, *Chairman*

HARRISON A. WILLIAMS, JR., New Jersey
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
FRANK E. MOSS, Utah
EDWARD M. KENNEDY, Massachusetts
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri
JOHN V. TUNNEY, California
LAWTON CHILES, Florida
DICK CLARK, Iowa
JOHN A. DURKIN, New Hampshire

HIRAM L. FONG, Hawaii
CLIFFORD P. HANSEN, Wyoming
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois
ROBERT T. STAFFORD, Vermont
J. GLENN BEALL, JR., Maryland
PETE V. DOMENICI, New Mexico
BILL BROCK, Tennessee
DEWEY F. BARTLETT, Oklahoma

WILLIAM E. ORIOL, *Staff Director*
DAVID A. AFFELDT, *Chief Counsel*
VAL J. HALAMANDARIS, *Associate Counsel*
JOHN GUY MILLER, *Minority Staff Director*
PATRICIA G. ORIOL, *Chief Clerk*

(II)

CONTENTS

Page

Statement by Senator Charles H. Percy, presiding ---- 4

CHRONOLOGICAL LIST OF WITNESSES

Brophy, Hon. Alice, commissioner, New York City Department for the Aging ---- 1
Beame, Hon. Abe, mayor, New York City ---- 2
Binstock, Robert H., Ph. D., Brandeis University, and president, Gerontological Society ----
Butler, Robert N., M.D., Director, National Institute on Aging ---- 10
Cooper, John A. D., M.D., president, Association of American Medical Colleges, Washington, D.C ---- 18
Schwab, Sister Marilyn, R.N., administrator, Benedictine Nursing Center, Mount Angel, Oreg ---- 28
Berliner, Robert W., M.D., dean, Yale University School of Medicine, New Haven, Conn ---- 32
Sherrod, Theodore, M.D., Ph. D., Department of Pharmacology, School of Basic Medical Sciences, University of Illinois at the Medical Center ---- 35
Libow, Leslie S., M.D., F.A.C.P., medical director, Jewish Institute for Geriatric Care; chief, geriatric medicine, Long Island Jewish-Hillside Medical Center, New Hyde Park, N.Y.; and associate professor of medicine, Health Sciences Center, State University of New York at Stony Brook, N.Y ---- 38

APPENDIXES

Appendix 1. Statements from individuals and organizations:
Item 1. Statement of Carter C. Osterbind, chairman, Public Policy Committee, Association for Gerontology in Higher Education, Washington, D.C ---- 49
Item 2. Statement of Eric Pfeiffer, M.D., chairman, clinical medicine section, the Gerontological Society ---- 51
Item 3. Statement of William E. Arnold, Multidisciplinary Committee on Aging, Arizona State University, Tempe, Ariz ---- 52
Item 4. Statement of Saul Kent, editor, Aging Tomorrow, New York, N.Y ---- 53
Item 5. Statement of Nona Boren, M.S.W., Michael McCally, M.D., and L. Thompson, M.D., of the George Washington University School of Medicine and Health Sciences, Washington, D.C ---- 54
Item 6. Statement of the University of Cincinnati Gerontology Council, Cincinnati, Ohio ----
Appendix 2. Letters from individuals and organizations:
Item 1. Letter and questionnaire sent to deans of medical schools in the United States by Senator Charles H. Percy ---- 61
Item 2. Letter from Earl C. Cooke, Houston, Tex.; to Senator Charles H. Percy, dated October 29, 1976 ---- 61
Item 3. Letter from Terrence T. Kuske, M.D., associate dean for curriculum, Medical College of Georgia, Augusta, Ga.; to Senator Charles H. Percy, dated September 24, 1976 ---- 62
Item 4. Letter from Bernard E. Nash, president, International Federation on Aging, Washington, D.C.; to Senator Charles H. Percy, dated October 22, 1976 ---- 62

Page

Appendix 2. Letters From Individuals and Organizations—Continued
Item 5. Letter from R. William Burmeister, M.D., medical director, Mount St. Rose Hospital, St. Louis, Mo.; to Senator Charles H. Percy, dated November 17, 1976 ---- 63
Item 6. Letter from William Reichel, M.D., project director, American Geriatrics Society, Inc., New York, N.Y.; to Senator Charles H. Percy, dated November 23, 1976 ---- 65
Item 7. Letter and enclosures from Raymond Harris, M.D., Center for the Study of Aging, Inc., Albany, N.Y.; to William E. Oriol, staff director, Senate Special Committee on Aging, dated October 28, 1976 ---- 68
Item 8. Letter and enclosures from Theodore R. Reiff, M.D., head, Division of Geriatric Medicine, University of North Dakota, Grand Forks, N. Dak.; to Senator Charles H. Percy ---- 78
Appendix 3. Material describing student education program ---- 85
Appendix 4. Announcements related to geriatric training in medicine:
Item 1. Articles from the American Geriatrics Society Newsletter, February 1977 ---- 90
Item 2. Abstract of the gerontology program of the George Washington University School of Medicine and Health Sciences ---- 91
Item 3. Northwestern University Medical School announcement of a new doctoral training program in the clinical psychology of the latter half of life ---- 92
Item 4. Letter and enclosure from Joseph M. Holtzman, assistant professor, Southern Illinois University School of Medicine, to Herman B. Brotman, consulting gerontologist, Falls Church, Va., dated March 2, 1977 ---- 93
Appendix 5. Statements submitted by the hearing audience:
Brooks, David Hall, New York, N.Y ---- 95
Byrnes, Gloria K., St. Paul, Minn ---- 95
Catlin, Carol, Chicago, Ill ---- 96
Cochran, R. Keith, Lubbock, Tex ---- 96
Combs, Robert C., Irvine, Calif ---- 97
Davidon, Ruth, San Francisco, Calif ---- 97
Day, Suzanne R., Ann Arbor, Mich ---- 97
Downey, Deborah, Euclid, Ohio ---- 97
Ellor, James W., Chicago, Ill ---- 97
Ferry, Margaret E., Bear Creek, Pa ---- 98
Follett, Sally, Waltham, Mass ---- 98
Fraser, Jacqueline L., Garden City, N.Y ---- 99
Gilfix, Michael, Palo Alto, Calif ---- 99
Goldfarb, Rose, New York, N.Y ---- 100
Gress, Lucille D., Kansas City, Kans ---- 100
Guillory, Ann Marie V., New York, N.Y ---- 100
Heppler, Jacque, Broomfield, Colo ---- 100
Jarvik, Lissy F., Los Angeles, Calif ---- 100
Josephson, Lucy, New York, N.Y ---- 101
Keshner, Ethel, New York, N.Y ---- 101
Kliesen, Sharon, Atlanta, Ga ---- 101
Loo, Katie, San Francisco, Calif ---- 101
MacHudis, M., New York, N.Y ---- 101
Murphy, Emily M., North Andover, Mass ---- 101
Otto, David A., Columbia, Mo ---- 102
Patterson, Marlene, Philadelphia, Pa ---- 102
Philipose, Vimala, Denver, Colo ---- 102
Porcino, Jane, Stony Brook, N.Y ---- 102
Rockwood, Catherine A., Dekalb, Ill ---- 103
Rouch, Jon H., Warren, Pa ---- 103
Schorr, Ann, New York, N.Y ---- 103
Skoronski, Jean, Chicago, Ill ---- 103
Snyder, Lorraine Hiatt, South Minneapolis, Minn ---- 103
Trelease, Joan Walsh, Narragansett, R.I ---- 104
Ummel, Mildred, Dayton, Ohio ---- 104
Vestal, Robert E., Nashville, Tenn ---- 104
Wichita, Carol, Tucson, Ariz ---- 104
Weiss, A. Kurt, Oklahoma City, Okla ---- 105
Zaks, Peggy Marcia, Detroit, Mich ---- 105
Zoot, Vicki, Skokie, Ill ---- 105

MEDICINE AND AGING: AN ASSESSMENT OF OPPORTUNITIES AND NEGLECT

WEDNESDAY, OCTOBER 13, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
New York, N.Y.

The committee met, pursuant to notice, at 8:07 p.m., in the grand ballroom of the New York Hilton Hotel, Hon. Charles H. Percy presiding.

Present: Senator Percy.

Also present: William E. Oriol, staff director; Deborah K. Kilmer, professional staff member; Dianna Porter, professional staff member; Wayne Fletcher, assistant to Senator Percy; John Guy Miller, minority staff director; Patricia G. Oriol, chief clerk; and Alison Case, assistant clerk.

INTRODUCTION BY DR. ROBERT H. BINSTOCK, PRESIDENT, GERONTOLOGICAL SOCIETY

Dr. BINSTOCK. Good evening, ladies and gentlemen. Welcome to the 29th Annual Scientific Meeting of the Gerontological Society.

To begin our program this evening I would like to introduce to you the Honorable Alice Brophy, one of our society's members, who is commissioner of the New York City Department for the Aging, a position she has held since 1968. As you know, Commissioner Brophy is a former chairman of the Urban Elderly Coalition.

Commissioner.

STATEMENT OF HON. ALICE BROPHY, COMMISSIONER, NEW YORK CITY DEPARTMENT FOR THE AGING

Commissioner BROPHY. Thank you, Bob.

Welcome to New York City. It is great to have you here and to say hello to so many colleagues and friends in the audience. The program is just great. I think it is going to provide intellectual stimulation and satisfaction to everyone. Of course, the best part of every conference is greeting and making new friends.

New York City has had a severe financial crisis. There has been a ripple effect throughout the country and many communities have been facing financial crises of their own—perhaps not as great or as acute as that which we faced in New York City—and yet we have not had a cutback in human services. There has been no diminution of programs for older people.

The programs that we provide for our senior citizens in New York City are unparalleled throughout the country. Our increased exemption program which provides subsidy for all people who are living on an income of $6,500 or less, and who are paying more than one-third of their income for rent, is unique. We have, as you know, a tax abatement program that 165 senior citizens in New York City created, and in our enclaves we are feeding 30,000 older people every day. We are establishing new programs within the next few months that will give older people new options, so that the only answer to their older years will not be a nursing home.

The person to whom I give credit for both the maintenance of all the ongoing programs and the introduction of new programs is our mayor. Despite the tremendous responsibilities that his administration has had to face, he has never failed to meet his commitment to the older people of this city. They have always had the highest priority. I am both delighted and privileged to present to you tonight the mayor of the city of New York, Mayor Beame.

STATEMENT OF HON. ABE BEAME, MAYOR, NEW YORK CITY

Mayor BEAME. Thank you very much, Commissioner Brophy.

I would like, for a few seconds, to express my very deep appreciation to Commissioner Brophy for the remarkable job she has been doing for the elderly of our city.

Senator Percy, Dr. Binstock, Dr. Berliner, Dr. Cooper, Dr. Butler, Sister Schwab, Dr. Sherrod, Dr. Libow, officers and members of the society, it is a great pleasure for me to welcome you to the city of New York on the occasion of the Gerontological Society's 29th annual meeting. During your stay here I am confident that each of you who represent different disciplines will expand our knowledge and understanding of the important issues which affect America's elderly population. I am pleased that you have chosen to meet here in New York City, the home of 1¼ million older Americans, many of whom will assuredly be affected by the results of your scholarship and deliberations.

Today our country must take a hard look at many problems crying out for solutions and those which affect the elderly must receive consideration and attention, not only by your, the experts, but also by the public. I am glad that you recognize this and are leading the way for change, and are pushing for action.

Times have changed, and people have changed with the times. It is imperative for all of us and for you, the leaders in the field of gerontology, to work for an end to age discrimination. It is time our society was restructured in a way which would enable our elderly to live the later years of their lives with a sense of fulfillment and a sense of dignity.

I was happy to learn that the opening session tonight will focus on health. The entire health delivery system requires new strategies and new solutions. Our distinguished chairman tonight, Senator Charles H. Percy of Illinois, has shown great leadership in the areas of health and aging through his work on the Senate Special Committee on Aging and the Senate Select Committee on Nutrition and Human Needs. I

am certain that the witnesses will contribute a great deal of valuable information at the hearings tonight.

I hope all of you will have the opportunity while in New York City to explore and enjoy its unparalleled cultural resources: its music, theaters, museums, and art galleries. In this Bicentennial year, we should remember that many older Americans, senior citizens of yesterday and today, built these world famous cultural institutions, established our educational institutions, designed our subways, constructed our highways, built our tunnels and bridges. We owe them our gratitude and we give them a respected place in our society.

So my warmest welcome and good wishes for a productive and a rewarding conference on a subject that in some way affects every New Yorker and every American. I know your work will help enlighten your fellow citizens.

Thank you.

Dr. BINSTOCK. Thank you, Mayor Beame, for welcoming us and for joining us.

Mayor BEAME. Thank you.

STATEMENT OF ROBERT H. BINSTOCK, PH. D., BRANDEIS UNIVERSITY AND PRESIDENT, GERONTOLOGICAL SOCIETY

Dr. BINSTOCK. We are honored and very fortunate to have as our opening program this evening an official hearing of the U.S. Senate Special Committee on Aging, with Senator Charles Percy of Illinois presiding. On behalf of all of our members, I would like to thank you, Senator Percy, for sharing this important public event with us.

Before yielding the floor to the distinguished senior Senator from Illinois, I would like to indicate how we came to have this program tonight. As you know, in the Gerontological Society's separation of powers, about the only program decision the president has is what to do with the opening evening session.

Now my feeling was that we have talked with each other too long, and that it was time to reach out and to have others reach in to us to discuss some of the very important issues facing the aging in this country. Therefore, I was delighted when I approached Senator Percy and the Senate Special Committee on Aging that they graciously agreed, several months ago, to hold this hearing here tonight as a proceeding of the U.S. Congress and to honor us by doing so.

By coincidence in the last few weeks, there has emerged a proposed Senate reorganization plan which, in its current version, calls for elimination of the Senate Special Committee on Aging. I am confident that the content of this evenings hearing will exemplify the important public service and leadership which is performed by the Senate Special Committee on Aging and demonstrate the need for its continued existence.

I would like to point out that on each of your seats there is a blue sheet on which any of you who wish to include a statement in the official record of this hearing can do so. Write your statement on that sheet, mail it to the Senate Committee on Aging within 30 day, and it will be included in the record.[1]

[1] See appendix 5, p. 95.

In addition, you will find a card on your seat. If there is time at the end of this hearing, we will read any specific, brief questions that some of you may wish to write on those cards addressed to a particular witness or to Senator Percy regarding the issues under discussion. Persons will be moving up and down the aisle to collect the cards if you will pass them toward the aisle. Write your questions on them and if we have time we will include some of these questions from the audience in the hearing.

Finally, I am sure you are all aware of the many important ways that Senator Percy has served the people of this Nation, as well as his own citizens in Illinois, in the field of aging. In particular, he has been very instrumental in helping to establish the National Institute on Aging, in helping to establish the program for multidisciplinary centers on aging, and he has participated in the recent committee investigation of frauds in medicare and in medicaid. In his own book, "Growing Old in the Country of the Young," he has expressed eloquently many of the major issues confronting people as they age in this country.

Without further ado, Senator Percy.

STATEMENT BY SENATOR CHARLES H. PERCY, PRESIDING

Senator PERCY. President Binstock, members of our panel this evening, members of the staff of the Senate Special Committee on Aging, and friends, I am very honored to officially convene this hearing of the U.S. Senate Special Committee on Aging. It will be recorded as such and a Senate document will be issued on this hearing.

I would like to say to President Binstock that we have never had quite this kind of setting for a Senate hearing, nor have we had as distinguished a panel. I hope we will keep our conversations as informal as possible and certainly share in it as much as we can. I have never convened a hearing where any one of the people in the audience could be an expert witness and where every word that is being uttered will be scrutinized by experts. We will have contrary points of view I am sure.

Certainly we have one thing in common, we are devoted to this field. It is a rather interesting thing that the first book I ever wrote was on the aging, but it was, to me, a natural sort of thing to do. I found at the age of 29, when I became president of Bell & Howell—in 1949—that I was also automatically the chairman of the Bell & Howell Employees' Retirement Association. Being a few years away from retirement I was not quite sure how to approach that job since it embraced everyone who had ever retired from the company and everyone who was approaching retirement age.

Through the years I was really quite shocked at how ill-prepared industry was to deal with this problem—how it looked upon its job only as a financial one—and following the life cycle of many people who did leave to find the shock that suddenly they were without a structured life. The kinds of problems they never thought they would encounter were numerous—problems of where to live, how to treat and handle their relationships with their friends, with their families, how to finance their retirement, the health problems, and nutrition problems.

We began a series very early in that period—the early fifties—of clinics and seminars beginning 10 years ahead of retirement with the members and spouses as well as the person who would be retiring from the company. I am happy to say that through the years we have had a marvelous experience and it gave me a wonderful background. I think I ought to be prepared to retire a few years from now having psychologically adapted and adjusted myself to it, and have had the privilege of working with so many other people.

For that reason I really look forward so much to being with you this evening. I think the Gerontological Society should be commended for suggesting that the issues before us deserve the attention of all of us. Through this forum I think we can share our conclusions, knowledge, findings, and research with the general public.

Medical Community "Lack of Concern"

As a member of this Senate Special Committee on Aging and the ranking minority member of the Subcommittee on Long-Term Care, I have been confronted with fairly solid evidence about the current lack of concern or knowledge by large segments of the medical community in regard to the illnesses and chronic disabilities which so often accompany aging. The Subcommittee on Long-Term Care, for instance, issued in the past year a special report which, when we issued it, I felt was a fairly shocking document about the relative absence of doctors and the difficulty of getting people who specialize in the particular problems of the aging in nursing homes. That report argues that this problem begins in medical schools where physicians of the future are trained primarily to deal with the medical problems of younger people. There is not proper attention focused on the problems of aging America and we must consider that aging America is becoming an increasingly larger part of our population through a number of factors, and it is growing very, very rapidly.

In our investigations we actually found, through testimony given to us, that doctors and physicians avoid dealing with the elderly, especially nursing home patients. The testimony varied as to why they did that. They testified before our subcommittee that they really elected and preferred to take care of younger people who can return to society. As one of them said, "We have a feeling we can return them to society as productive members." They have a concept that an elderly person was not going to be returned to society as a productive member, which is part of the psychological concerns of older people—that they are being shelved and left out, they are forgotten, and they are being dealt out of society.

That is why we have so many programs such as foster grandparents, and others, specifically designed to encourage older people who recognize there is a real role they can play in society. They are highly productive members in many other societies from whence we all originally came, and why, suddenly, when they come to the United States should they be shelved and why should they be regarded as though they are out of the mainstream of activity? Possibly that is why drug abuse is so high among older people.

We are told that unrealistically low medicare and medicaid fees and the associated red tape actually causes many physicians to decide not

to deal with the elderly. Another less obvious reason we found for the lack of physician interest in older people has been described as the Marcus Welby syndrome. The psychological reinforcement that comes from seeing the sick cured is not thought to be available in the context of the infirm elderly. One doctor—I will just quote his words—testified before us and said, "I hate nursing homes. I never go there. I get too depressed. I never feel like I am doing any good for anyone."

I wrote a book really to try to interest people in the fact that nursing homes, where a million people are in this country, can be made places of dignity and respect, of cheer and hope. Mrs. Percy and I have probably visited more nursing homes than anyone I know of—certainly in the Congress of the United States. We were in three this week. My mother has played the violin and played concerts, I think, in over 30 nursing homes in just the last year, and she has been doing it for years. She is my favorite senior citizen. Anyone that tells me they can only get depressed going to nursing homes have not been in them as recently as I have because there has been a vast change in many.

Nursing Homes Investigated

Senator Moss and I conducted hearings all over the country on nursing homes. We have driven people out of business that were in the business of making money on the elderly. We have broken up syndicates right here in New York. We have indicted and jailed people who were building up fortunes—millions of dollars—at the expense of the sick, particularly if they were old. We have changed, a great deal, the attitude of the State inspection offices and city inspection offices toward nursing homes. The Electrical Workers Union ought to thank our subcommittee, at least, because there has been a tremendous change.

There is still a long way to go, but there is improvement. For those who think that they cannot get any inspiration out of a program we started in Illinois—with all due respect to the comments made about New York having the greatest program—Mayor Daley would resent that; I don't think I have ever spoken for him before on behalf of Chicago—a program in high schools and community colleges which allows young people to go into nursing homes. I for one saw many nursing homes and looked at the guest register books and found that in 1 week two people visited the 100 people there. So we got high schools and colleges to bring young people to do just ordinary sorts of things—help with telephone calls, write letters, just sit and talk or read the newspapers, something like that.

I think what we have to do is encourage the medical profession to also look in that direction. There is so much opportunity for service. I wrote last month to 114 medical schools and put a series of questions to them and possibly, during our question-and-answer period, we can bring out some of their answers. We had a flat answer as to why there is not this interest. We must stimulate interest in the medical schools for we are still a long way from having much attention paid to geriatrics in our medical schools.

[The prepared statement of Senator Percy follows:]

PREPARED STATEMENT OF SENATOR CHARLES H. PERCY

Thank you, Professor Binstock, for describing the special circumstances which have led to this hearing tonight. And thank you, as well, for your own personal initiative and concern throughout all our preparations for this event.

The Gerontological Society, I think, is to be commended for suggesting that the issues before us deserve attention, not only before this distinguished audience, but before the press and public.

As a member of the Senate Special Committee on Aging and as ranking minority member of its Subcommittee on Long-Term Care, I have been confronted often with solid evidence about the apparent lack of concern or knowledge by large segments of the medical community in regard to the illnesses and chronic disabilities which so often accompany aging.

The Long-Term Care Subcommittee, for example, has issued within the past year a special report about the relative absence of doctors in nursing homes. And that report argues that this problem begins in medical schools, where physicians of the future are trained primarily to deal with the medical problems of young people.

In our investigations we learned that many physicians avoid dealing with the elderly, especially nursing home patients. Many doctors have testified before our subcommittee that given the demands on their time, they elect to take care of the younger people who can return as productive members of society. We were told that unrealistically low medicare and medicaid fees and the associated redtape greatly discourage physicians from caring for the sick and the elderly.

Another less obvious reason we found for the lack of physician interest in old people has been described as the "Marcus Welby syndrome." The phychological reinforcement that comes from seeing the sick "cured" is not thought to be available in the context of the infirm elderly. One doctor told us candidly, "I hate nursing homes. I never go there. I get too depressed. I never feel like I am doing any good for anyone." In our report we took exception to this notion, pointing out that dramatic improvement and often full recovery are possible even with the most infirm nursing home patients. Sometimes the remedy is as simple as taking the patients off of all the drugs they have been receiving.

I for one think we can expect a great deal more from our medical profession than we are now receiving.

I for one think that the medical profession should extend its blessings to all persons in all age groups, in full understanding of the needs of individuals in each group.

I for one know that today's failures to deal with the illnesses and frailties of aging will grow as the numbers of older Americans grow: 23 million today, about 31 million less than two and one-half decades from now, when the new century begins. Much of that growth will take place in the very highest age brackets, where the likelihood of long-term illness and incapacity is the greatest.

If we have problems now, we'll have superproblems later, unless we change a few attitudes and practices.

If this is already my conviction, why are we having this hearing? We have called expert witnesses to argue both sides of the medical school issue, but I have to admit right here and now that I am swayed very much by the findings of our latest survey of what is actually happening right this minute in schools of medicine around this Nation.

Last month I wrote to the 114 schools of medicine asking them three questions: Do you have geriatrics as a specialty in your curriculum? Do you have programs in which students, interns, or residents serve in nursing homes? Do you have programs which help serve nursing homes in some other way?

Medical School Survey: Results

I received 87 replies to my questionnaire. Three schools of medicine indicated they had established geriatrics as a specialty in their curricula. They were the University of Health Sciences at the Chicago Medical School, the Arkansas College of Medicine, and the University of North Dakota. Seven schools, including the University of Pittsburgh and Duke University, were viewed by the staff as very close to this goal.

In short, of the 87 schools who answered my inquiry, a total of 10 said they had a specialty in geriatrics or were in the process of doing so. Thirty-five schools said they had programs whereby students or interns worked in nursing homes. Forty-seven schools said they had other programs to serve the elderly, particularly nursing home patients. These programs reportedly ran the gamut from research in gerontology to out-patient clinics or day care centers for the elderly.

A comparison with the results of our previous questionnaires provides valuable insight. In 1970 no school had or was contemplating a department of geriatrics; only six said they had a program whereby students or interns serve nursing homes, and seven said they served the elderly in some other way.

In 1974, 13 schools said that they either had a specialty in geriatrics or were contemplating creation of such a specialty. Counting three schools who did not reply this year, the results of our 1974 and 1976 questionnaires appear to be identical on this point.

In 1974 a total of 74 schools said they had a program whereby students or interns could work in nursing homes. This year only 35 schools responded positively. As interpreted by the staff, there is an apparent decrease in interest in this area of sizable significance. Since we received 100 replies in 1974 and 87 replies this year, a look at percentages may make our comparison of the relative interest in nursing homes more meaningful. In 1974, 74 percent of the medical schools indicated having a program whereby students or interns could fulfill requirements by serving in nursing homes. This year only 43 percent of the medical schools indicated having such programs.

In 1974, 53 percent of the medical schools reported serving the elderly in nursing homes in some other way. This year 47 schools or 59 percent reported programs to serve the infirm elderly.

In summary, if our questionnaires can be taken at face value, there seems to be a slow but increasing awareness in the schools of medicine of the medical problems of the aged. There is increasing interest in the creation of departments or divisions of geriatrics; however, only

three such units have now been created. Finally, there seems to be a decreasing concern in programs which allow students or interns to fulfill requirements by working in nursing homes.

The latter finding is of particular interest to me because of my concern for nursing home problems as spelled out in my book, "Growing Old in the Country of the Young." I think the finding is all the more significant because of new research findings I am making public tonight with the permission of my good friend, Ethel Shanas, professor of sociology at the University of Illinois in Chicago. Ethel is to give a paper later this week summarizing a few points from her latest research in the United States and abroad. Several of her points bear analysis here:

—Only about 5 percent of people 65 are now in institutions, and 4 percent 11 years ago. But in 1965, the 4 percent figure totaled 650,000 persons. Now, because of the growth in our upper age population, that figure is about 1 million.

—Challenging as the institutional care situation is, there is a greater challenge facing our health care system, if we will only face up to it. In 1962, 4 years before medicare, 2 percent of the elderly were bedfast, and 6 percent were housebound.

Is Medicare Serving Housebound?

In 1975, 9 years after medicare became operational among the elderly in the community 3 percent were totally bedfast and 7 percent were housebound. In both 1963 and 1975, then, there were twice as many elderly bedfast and housebound as there were in institutions: 10 percent compared to 5 percent. Ethel says, the enactment of medicare then has not reduced the proportion of the elderly living in the community who are bedfast or totally housebound.

And so we must ask ourselves whether medicare is doing what it should do to encourage health maintenance and forms of care which will release persons from their homes or make their confinement more tolerable.

We must also remind ourselves that while the proportions of housebound and bedfast remained similar between 1963 and 1975, their numbers did not. They are on the increase as the number of elderly, particularly the very elderly, continues to increase.

A satisfactory response to these challenges cannot be fashioned without the full cooperation and understanding of the entire medical community. If, in every way possible, physicians join in the effort to keep our older citizens functioning as fully as possible for as long as possible, we have a better hope of fulfilling the full potential of our older population and our health care personnel and facilities.

I realize that one of the greatest obstacles we face is what one of our witnesses—Dr. Robert Butler—calls "age-ism, or negative attitudes toward aging and everything associated with aging.

Some measure of the magnitude of that prejudice—and the challenge we face when we try to do something about age-ism—can be found in the papers I have in my hand. They are excerpts from a scholastic aptitude test given by one school system in Pennsylvania. One of the words on which the students are tested is "senility," which I think we all agree is a specialized word indicating a clinical condi-

tion. But I think we all know that senility is a much misused word. It's been said often that when a middle-aged person forgets something, that person is called absent-minded. But let that happen to an elderly person, and that person is called senile.

To get back to the scholastic aptitude tests, there's a little poem in which the missing word is to be filled in. It reads:

"First we're little cooing babes,
And haven't much ability,
But just when we think we're getting wise,
We're suddenly in ————."

Fill in the missing word. You guessed it. (Senility.)

Later in the same test, there is a crossword puzzle calling for an 8-letter word synonymous with old age. Fill in that word. You guessed it. (Senility.)

A few days ago, the *Washington Star* newspaper published a front page survey on what children think of elderly people. The results coincided with a number of myths about elderly persons which I dispel in my book, "Growing Old in the Country of the Young."

As stated in my book one of the biggest myths is that most of the elderly suffer from serious mental deterioration and senility. This, of course, is not true. Intelligence is measured in tests of comprehension and knowledge, and shows little or no decline for the average elderly person. According to Dr. Robert E. Rothenberg, "mental deterioration rarely occurs among normal older people before the eighties." Furthermore, evidence indicates the ability to think and reason increases with age if those facilities are given sufficient use.

Several other myths that we need to dispel are that: most of the aged are disabled; older people cannot cope with change; most men and women over 65 have no sexual interest or activity; all older people are alike; old age is a disease and physical limitations imply an inability to function.

If our youth as well as many of our adults believe these myths, it is no wonder that today's medical students are not adequately trained to cope with the illnesses of the elderly. Or are they?

We have invited witnesses who may have varying views on that subject, and we will hear from them now. I am looking forward to a lively and informative discussion.

[End of prepared statement]

Senator PERCY. If our panelists would be good enough to come up to the podium.

We are very pleased to have as our first witness this evening Dr. Robert N. Butler, Director of the National Institute on Aging.

Dr. Butler.

STATEMENT OF ROBERT N. BUTLER, M.D., DIRECTOR, NATIONAL INSTITUTE ON AGING

Dr. BUTLER. Senator Percy, Dr. Binstock, gentle people, good evening.

In order to effectively meet the needs of older people for high quality medical treatment—accurate diagnosis, sensitive care, and effective treatment—it is imperative that the special perspective of the particu-

lar body of knowledge known as geriatric medicine be introduced into the curricula of our 114 medical schools, into our intern and residency training, and into our programs of continuing education. In this country today we have some 330,000 practicing physicians, many of whom are not equipped to meet the needs of today's 23 million old people—a situation which is likely to grow worse as the number of older people increases by almost 50 percent in the next three decades.

The real question is not whether geriatric medicine should be a specialty, certified or otherwise; that is essentially proprietary. Rather, the question is how can we expose every physician to the procedures of primary care which are necessary to deal with older patients just as we have exposed other primary care physicians—pediatricians, family and general practitioners, internists, and gynecologists. The body of knowledge required to care for old people is not just disease-categorical; it is broad in perspective and in keeping with the complex character of human experience—including the multiple physical, personal, and social processes that occur with age.

Geriatric Training Stimulated

There are signs of increasing interest in the teaching of geriatric medicine. The Student American Medical Association (SAMA) has called for its incorporation within the medical school curriculum; the Council of Medical Education of the American Medical Association may also now support such teaching; and the Administration on Aging has provided some funds.

Surprisingly, a recent survey of American physicians reported in the September 27, 1976, issue of Impact, an AMA news periodical, revealed that 75 percent of practicing physicians answered affirmatively the question, "Do M.D.'s need special training in geriatrics?"

At our own institution, the National Institute on Aging—part of National Institutes of Health—we are all too conscious of the negligible degree to which investigative medicine is involved in the study of the physiology of the aging human organism. We are convinced of the necessity of having more geriatric medicine taught so that it may serve as a catalyst for the research that forms the framework of a good service delivery system. By expanding our knowledge of human aging, we will ultimately enhance the quality of life of the later years and also help alleviate the great financial and emotional pressures placed upon the middle-aged and younger generations to care for the old. In addition, we would also reduce our incredible national health expenditures, many of which are associated with the disabilities and diseases of old age.

The argument on behalf of geriatric medicine is based on compelling necessities—intellectual, demographic, epidemiological, cost, and attitudinal—which can neither be avoided nor evaded. Practically speaking, the first argument in favor of the inclusion of geriatric medicine in our medical schools is that this body of special knowledge already exists, far from complete but nonetheless substantial. This fact is quite contrary to the commonly held notion that there is not even so much as a textbook on the subject.

In the disciplines known as human physiology and pathophysiology exist the data that underpin geriatric medicine. These data deal with

the differentiation of time-related changes from pathogenetic elements, from the results of socioeconomic adversities, and from the effects of personal crises. The characteristics of the changes inherent in late life can be distinguished from the concomitant crush of environmental events. Making these distinctions is the first critical step in recognizing, diagnosing, and then ameliorating what can be changed. With time comes an accumulation of long-term diseases such as arteriosclerosis and disabilities such as joint-trauma.

Symptoms of Elderly Misleading

In the later years, multiple disorders are present as the body's protective mechanisms such as immunity are compromised. Symptoms present differently in the old, and the untrained clinician often misses the diagnoses:

(1) An older person with hyperthyroidism may appear apathetic, not hyperactive.

(2) Tuberculosis may proceed in silence.

(3) Appendicitis may occur without the characteristic abdominal tenderness at McBurney's point, without fever, and without an elevated white count.

(4) An older person may even have a heart attack without chest pain and may instead appear confused, disoriented and seem like the victim of a stroke.

The second argument for the teaching of a geriatric medicine is demographic. Persons 65 and above constituted 3 percent of the American population in 1900; 10 percent by the second White House Conference on Aging in 1971; will perhaps constitute 12 percent by the turn of the century; and some 17 percent between 2015 and 2020. The latter figures are predicated upon there being no improvements in the delivery of health care or any achievements in research, assumptions which are regarded as unlikely. It is far more probable that in 2020 one out of every five American citizens would be over 65 years old. With that kind of "2020 vision," we see the same Americans that constituted the post-World War II baby boom, those youngsters who were described as "greening" America, "graying" America. I, as a middle-aged father of three post-World War II children, am conscious that it is my children who will enjoy or suffer the consequences of the old age created for them here today.

The third reason for including geriatric medicine in our medical schools is epidemiological. If we are to have a good, responsible health care system, we must first accurately and realistically measure the proportions of the problem with which we are trying to deal. For example, we have to be able to take into account the high incidence and prevalence of disorders which accumulate or develop for the first time in the later years. One of these, senile dementia—so devastating to human personality, identity, and memory—is perhaps the fifth greatest killer in the United States and probably the reason at least 50 percent of the patients enter American nursing homes. Diabetes, rheumatoid arthritis, osteoporosis, cardiovascular and cerebrovascular diseases, and many more require delineation and epidemiological consideration so that our health care system will respond effectively.

The fourth imperative is cost. We in this country spent some $118.7 billion on health in 1975. Of this staggering figure, some 50 percent—$60 billion—went for chronic disease, and one-third of all acute hospital beds were used for old people. There were 1.2 million patients in 23,000 nursing homes in 1975—more patients than in our over 7,500 voluntary hospitals. Nearly one-fourth of all drugs consumed in this country were consumed by older Americans. The litany is endless.

Haphazard service delivery, resulting from incompletely trained diagnosticians and technicians, costs money. Without an "educated," sensitized corps of doctors and service delivery personnel, no new ideas germinate; new research dries up; and our health care systems stagnate. Moneysaving and timesaving, as well as lifesaving, measures cease to find their way into use.

Elderly: The American Attitude

Perhaps at the root of our failure to adequately provide for our older people is an attitudinal problem. Americans suffer from a personal and institutionalized prejudice against older people. Although this may be a primitive, universal dread of aging true in all cultures, it is reinforced and thus more striking in our own. This is a cultural sensibility that could be changed through study and education. When the medical student or the doctor shares in that negative attitude, it is all the more disturbing. The first older person that the average medical student meets in medical school, aside from some of his teachers, is the cadaver. Although many professors of anatomy thoughtfully indicate the need for respect for the body as a dissection begins, few American medical schools pay attention to the disturbing dreams, the nightmares, the nausea, the vomiting, and the confusion that the medical student faces in response to the dismemberment of the body. It is a small wonder, then, that the student, left to his or her defenses and coping mechanisms, develops a negative attitude. "Gallows" humor emerges. Youth oriented Peter Panism, or callous and cruel epithets such as "crock," "turkey," "toad," and the one I just heard—"dirtball"—becomes synonymous with the older person.

One study of University of California medical students [Spence, Feigenbaum, et al., *Journal of the American Geriatrics Society*. 6: 1976–83, 1968] showed that their attitude toward old people actually deteriorated over the course of their 4 years in medical school. Medical students are not exposed to healthy older people in the same fashion that they are exposed to healthy babies in sunny, well-baby nurseries and clinics. In fact, there isn't a medical school in the country which routinely and systematically rotates students through community senior centers. One wonders whether medical students would choose to be pediatricians if they only saw babies suffering from irreversible conditions. However, there are some signs of change. At NIA we plan to cosponsor conferences related to geriatric medicine and research with the American Geriatrics Society. The Institute also has the legislative authority to support postdoctoral training in geriatric medicine and to consider research centers in medical schools. We are actively encouraging the introduction of sections on special considerations related to aging in the classic American medical textbooks, an

idea arrived at independently by Drs. Reuben Andres and Leslie Libow.

Also, we are exploring the possible use of the mechanism of a faculty grant—an idea of Dr. James Shannon, former director of the National Institutes of Health—to help support research in geriatric medicine in American medical schools. The elements necessary for curriculum development are more or less in place. The question is, how do you create eggs without chickens? There are no homegrown geriatricians in the United States. Therefore, we need to develop faculty. Current estimates are that perhaps less than 15 of an estimated 25,000 faculty members of American medical schools have any genuine expertise in geriatric medicine. Summer and winter workshops, as well as some circuit writing by outstanding European geriatricians, might help.

We can learn much from nurses and medical social workers, who are ahead of American medicine in the area of geriatrics. We can surely learn from the "impoverished" United Kingdom, with its 10 endowed chairs of geriatric medicine, or from little Sweden with two chairs, or even Holland, which recently created its first. We, a country of some 200 million, still do not have a single endowed chair in geriatric medicine.

NIA Study of Curriculums

At the NIA we are doing a study to analyze human development courses in American medical schools to find out: How many of the 114 schools have them; for how many hours; and of those hours, how many are devoted to the middle and later years? We can also support studies that would evaluate techniques for intervening and changing the attitudes of medical students toward aging and the aged.

There has been much discussion recently of an Institute on Medicine study of medicare reimbursement which pays for the salaries of interns, residents, and attending physicians teaching in America's teaching hospitals. I cannot help but wonder if that flow of money might not be more closely examined to determine if it might not better be used as resource funds for the teaching of geriatric medicine or for the conduct of investigative studies to give additional benefit to medicare participants.

It would be most constructive to undertake sample testing of the clinical knowledge in geriatric medicine of the 330,000 graduate physicians in the United States. Questions on geriatric medicine, if incorporated into examinations by the American Board of Medical Examiners, would provide a clear incentive to American medical schools to teach care of the aged.

Fortunately, consumers in this country are becoming more vocal, and this includes matters concerning old people. Certain groups have begun to express an interest in why so few American medical schools teach geriatric medicine—32 electives among 114 medical schools. This lack of training is exacerbated by the absence of special considerations related to the aging patient in our classic textbooks of medicine and pharmacology.

Our Institute, in its efforts to create a climate for the development of quality investigative medicine in aging, is not only considering the support of biomedical research centers in medical schools, but hopes

that universities will pioneer by creating university-wide committees on aging and geriatric medicine in the expectation that this would foster innovative multidisciplinary research.

In addition, the National Institute on Aging should attract and utilize clinical and research associates in our intramural program in Baltimore—the gerontology research center—where investigative medicine could proceed without difficulty.

I am always struck, after my many years of research and clinical practice, at how colleagues who had been indifferent, if not hostile, to the idea of teaching geriatric medicine will call me when illness strikes a mother, father, wife, husband, or themselves. Then, even they recognize the need for a speciality or expertise.

I do not wish to ignore the somewhat understandable complaint of medical school deans that they already have an overcrowded curriculum, and therefore no room for geriatric medicine. I would like to reply to these complaints by pointing out that new developments in science have been incorporated before in areas such as neonatology and nuclear medicine.

Second, I would like to reiterate that we simply cannot deny geriatric medicine a place in the curriculum, because we cannot afford to do so—financially, demographically, or attitudinally.

Finally, no medical school has ever taught all that might be taught or could be taught. What we want is for students to learn how to learn. They need to learn how to approach a problem, a category, a situation. There are ways of interchanging content while still looking at the process. For example, one can learn about pharmacology by looking at older people and children as well as adults. One can learn the principles of neuropathology with careful attention to newer knowledge related to cerebrovascular disease and senile dementia.

A Task Force on Geriatric Medicine?

In closing, let me emphasize that this is a complex and important subject which requires and deserves our every consideration. It would be a most constructive step if the Institute of Medicine of the National Academy of Sciences would create a national task force on geriatric medicine to consider the best means of introducing the teaching of geriatric medicine, implementing service delivery for the aged, and encouraging research on aging in medical schools. At the same time, we at the NIA will pursue the subject of geriatric medicine through:

(1) Curriculum development;

(2) Faculty development;

(3) Study of teaching in the United Kingdom;

(4) Collaboration with American foundations;

(5) Coordination with the Veterans' Administration hospitals, especially where there are Geriatric Research Educational Clinical Centers—GRECC's;

(6) Association with the senior medical consultants—originally NIH funded—a body of emeritus professors in various medical specialities who teach in nonuniversity affiliated hospitals;

(7) Exploration of possible means of support of geriatric medicine and nursing education with the Administration on Aging, the Health

Resources Administration, the Bureau of Health Manpower, et cetera; and

(8) Discussions with the private sector—the National Retired Teachers Association and the American Association of Retired Persons, National Council of Senior Citizens, the American Health Care Association, et cetera.

Thank you very much.

Senator PERCY. Thank you very much.

Dr. Butler, as I related, is the Director of the National Institute on Aging; he has worked with the elderly for over 20 years in the fields of psychiatry and psychology and has authored many books relating to aging, including his Pulitzer Prize winner, "Why Survive? Being Old in America." I would imagine it sold more copies than mine.

Dr. Butler, our format is that the panelists will be asked to speak for 8 minutes—we will give them 1 minute notification in advance. I will ask a couple of questions of each of you as we go along, and then we will open it for discussion and questions from the audience at the end. This is a rather unusual procedure for a Senate hearing but I ask unanimous consent to do so. There is no other Senator here to dissent; therefore, it is so ruled.

I will submit all of the questions I have for our witnesses and ask them to answer. We will hold the record open for several weeks so that it is complete. I think I would really prefer to have as many questions from the audience as possible.

There are cards for which to write your questions and then you may send them up. The cards will be picked up and your president will read the question.

THE SWINE FLU VACCINATION

Now, Dr. Butler, let me give you a noncontroversial first question. Could you give us your expert opinion as to the relationship between the swine flue vaccination and the recent deaths of 11 elderly people now in 3 different States?

The city of Chicago is going ahead with the vaccinations, downstate Illinois has stopped them. We have a condition of uncertainty about this whole program. Could you tell us about that?

Dr. BUTLER. Well, it is a very serious matter and for that very reason I have to disqualify myself in terms of any expert opinion on the matter. I was deeply concerned over the summer knowing that, as part of our responsibility at the National Institute on Aging, we had to be concerned about questions that would relate to the swine flu vaccination program.

I was also interested from a research perspective because presumably the aged population might already have had immunity, having gone through the 1917–19 flu epidemic. In pursuing this question at some depth, however, I discovered that the swine flu virus was not really isolated until 1931. Therefore, we cannot be absolutely certain that that is the same virus which was so devastating to both Americans and people throughout the world.

I, of course, feel that we must investigate the problem. I am also deeply concerned that our population be properly protected should

we have a major epidemic. I don't think panic is in order but, rather, wisdom.

Senator PERCY. We will leave that question for any of the other panelists when it comes their turn to comment after their presentations if they wish, or if we have any expert advice in the room beyond the expertise of the newspaper reporters that we have had, we would certainly appreciate it.

I would like to ask, Dr. Butler, if you have had a chance to study Senate bill S. 1156, a bill to create grants to encourage medical schools in the establishment of departments of geriatrics. If you have had a chance to study it, would you care to comment on the underlying comments of that bill?

Dr. BUTLER. I think that one very important incentive to the introduction of geriatric medicine certainly could be the provision of funds. I think there are other forms of incentives, too, which are very important to us.

I would like to go back to the question of faculty development. If we do not have an adequately trained faculty which understands the basic corpus of knowledge in geriatric medicine, we are at a loss. Perhaps some of that incentive money, should it come into being, should be allocated specifically to creating a cadre of outstanding models of knowledge in the area of geriatric medicine, who could then in turn teach others in a kind of ripple effect.

PHARMACOLOGY OF AGING ESSENTIAL

Senator PERCY. The last question that I would like to put to you, I put to you simply because 30 million people saw it on "60 Minutes" and wondered about it. The "60 Minutes" television program had a psychologist who said that he had received his training in prescribing drugs for insomnia by watching the resident he followed around on his rounds. It disturbed many people because many of the responses to our survey at medical schools stated that their own training in geriatrics was the student's exposure to the older patient and the care provided by the doctor in charge.

Is this "watching of the resident on duty" type of training common in medical schools and isn't it most dangerous, especially in such instances as prescribing of drugs for older patients who often react differently to such drugs as amphetamines and stimulants?

Dr. BUTLER. It is essential that we develop the pharmacology of aging. We have the tools, the concepts, and the instrumentation to do so. It is quite surprising, as I mentioned earlier in my testimony, that our major classic textbook in pharmacology does not even have "age" in the index. In our Institute, we plan to support studies that will help change prescription guidelines as they affect the older patient. I think that without new guidelines, we continue to run the risk of overutilization of drugs, with resultant confusion that may be misdiagnosed as so-called senility. Too often, a patient is hospitalized or institutionalized unnecessarily.

Senator PERCY. Dr. Butler, thank you very much indeed.

Dr. John A. D. Cooper is president of the Association of American Medical Colleges. The AAMC is the professional association of the 117 medical schools in our country. Dr. Cooper was dean of science at

Northwestern University prior to his work with the AAMC and was associated with Northwestern in professional roles from 1943 to 1969. He received both his Ph. D. and M.D. from Northwestern University.

Dr. Cooper.

STATEMENT OF JOHN A. D. COOPER, M.D., PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, D.C.

Dr. COOPER. Thank you very much. I appreciate the opportunity to present the statement of the Association of American Medical Colleges on medical education and the health problems of the elderly.

At the outset it is very important to recognize that in this country no organization, including the AAMC, has control over the curricula of medical schools. Detailed specifications of curriculum content has fortunately been avoided, since that process tends to impede innovation and to construct an inflexible program of instruction not responsive to advances in medicine, in medical science, or in new patterns of medical service.

The strength and excellence of American medical education is due in large part to the great diversity and individuality that characterizes the academic institutions that educate physicians. The medical schools vary in age, sponsorship, tradition, and goals, but in different ways each has made important contributions to better medical care through its education, research, and service programs which have generally been acknowledged to be in the forefront of all such programs in the world. Thus, it is to be expected that the schools would have responded in a variety of ways to the unique and growing challenge presented by the Nation's aging population.

MEDICAL CENTER'S ROLE

The task of the academic medical centers in preparing physicians to assume their appropriate responsibilities for services to the elderly is threefold. Medical students must be educated:

(1) To understand the normal aging process. Conceptually, this is best approached as part of the study of growth and development.

(2) To diagnose and care for the diseases most likely to impair function and threaten life in the elderly.

(3) To adjust the provision of medical services toward the effective management of chronic disease over long periods.

Within the limits of present knowledge about the aging process, it is possible to educate students about the nature of aging, either through special courses on this subject or in a sequence of courses, in which growth, development, and aging are interwoven. While the degree of emphasis differs from school to school, education about the aging process is provided effectively in all U.S. medical schools.

Additionally, elderly patients with acute illness are commonly encountered in teaching hospitals, and demonstrations and instruction on the diagnosis and treatment of these illnesses, with a special focus on the character of their manifestation in the elderly, is a commonplace occurrence in every school and every teaching hospital.

The principal problem area in educational and learning opportunity in our academic medical centers is in the long-term management of

chronic, or only slightly disabling, conditions in patients who are outside the mainstream of contemporary society. In this domain, the medical schools have selected a wide variety of approaches.

Just as there is variety in the ways that undergraduate medical education has responded to the unique challenges presented in the medical care of the elderly, so also have there been wide differences in approach at the graduate level, subsequently reflected in professional practice patterns.

Some physicians view geriatrics as a distinct specialty warranting specific residency training programs and subspecialty recognition, while others think that it is orthogonal to all specialties and that the aged will receive better care if all appropriate specialists participate in their management. Since the AAMC does not now directly participate in the process of the creation of new specialties, this organization's preference on whether geriatrics should be a separate specialty is an academic question.

Longevity Can Increase Problems

In teaching students about the problems of the elderly it is difficult to isolate the medical from the closely interrelated economic and social needs of this group. Furthermore, the interactions of these variables becomes increasingly complex as the elderly population expands. Dr. George Maddox, director of Duke University Centre for Aging and Human Development, in describing the size of the task ahead in a recent issue of *Annals of Internal Medicine*, said:

> Long average life expectancy, a distinct achievement of modern societies, has proved to be an embarrassment and a current threat to existing institutional arrangements, not only for health and welfare, but also for income maintenance, transportation, housing, and education. Medical education and health delivery systems in both countries (England and the United States) were designed for acute, not chronic, illness; they are, therefore, mismatched with the particular needs of older persons for preventive, primary, and long-term care. . . . The mismatch is troublesome in the United Kingdom and dramatic in the United States.

Thus, greater attention must be given to educating students in an understanding of the social milieu of the elderly. This requires emphasis not only on disease processes, but on the management of the patient's social adjustment problems, an objective not easily achieved unless the medical student has the opportunity to see the patient outside the hospital setting.

Debate on the technical and policy issues related to the creation of a specialty and on the appropriate approach to teaching geriatrics should not be allowed to obscure the very basic reality of how extraordinarily limited the body of knowledge about gerontology actually is. To achieve meaningful and significant solutions to this set of problems, greatly increased energy and effort must be committed to research in gerontology and a far larger fraction of the Nation's most creative aspirant scientists must be trained in this area of medical science. The association, therefore, strongly supports a rapid buildup of resources for the National Institute of Aging and feels that its broad charter, which includes research in the social and behavioral, as well as the medical aspects of aging, is most appropriate.

Medical educators are keenly aware of the dimensions of the educational challenge presented by the medical care problems of the elderly, and are generally responding effectively by developing a variety of educational approaches for undergraduate and graduate programs.

Financial Problems

That medical schools could do more is undeniable, particularly in terms of student-patient encounters in ambulatory settings, nursing homes, and extended care facilities. The major obstacle to this relates to the problems of financing, both undergraduate and graduate, medical education. Ambulatory care teaching has presented the Nation's medical schools with particularly serious financial problems. A large number of outpatients have inadequate medical care insurance or are totally uninsured. Those with coverage are often unable to pay deductibles and coinsurance. Moreover, some coverage, such as medicare, reimburses on a scale often well below what is customary and prevailing and excludes from reimbursement under "part A" the costs of the education of interns and residents in outpatient facilities. Finally, when the education of students and residents is coupled with patient care, inefficiencies are introduced that increase unit costs and prevent a high volume flow of patients. All of these factors summate in a situation in which the ambulatory care services of our teaching hospitals are incurring substantial fiscal losses and will not be able to significantly expand their ambulatory educational and service programs without adequate reimbursement for them.

Thus, development of optional pedagogic programs must await the day that medical education is on a more sound financial basis. Valuable interim assistance will be provided by the special project grants for undergraduate and graduate education in areas such as family medicine, general pediatrics, and general internal medicine, authorized in the Health Professions Educational Assistance Act of 1976 signed yesterday by President Ford, especially in making possible high-quality ambulatory care education for students and residents. But all medical care programs proposed in the future must reimburse the costs of educating the health professionals essential to provide the needed services if the advances of medical science are to be brought to the beneficiaries of the program.

In summary, the association fully supports efforts to improve education for providing the teaching of first-class medical services for the elderly in the Nation's medical schools. The efforts of the medical schools can and will improve immensely as the body of knowledge of gerontology, which is now woefully inadequate, increases through research, and the financing system is modified through legislation to place undergraduate as well as graduate medical education on a solid financial basis.

Conflicting Testimony

Senator Percy. I was particularly interested in your testimony where you said that education of the aging process is provided effectively in all U.S. medical schools. That seemed to challenge Dr. Butler's statements and at the same time were somewhat in contrast with the questionnaires I received. As I mentioned in my opening comments, I

wrote to 114 schools of medicine last month and I put to them such questions as this: Do you have geriatrics as a specialty in your curriculum? Do you have programs in which students, interns, or residents serve in nursing homes? Do you have programs which help serve nursing homes in some other way?

Only 3 schools of medicine of the 87 that replied to the questionnaire actually indicated that they have established geriatrics as a specialty in their curriculum. Seven others seemed to be indicating that they were working toward that goal and recognized that they should have them. I was particularly discouraged by the fact that several years ago 74 percent of schools said they had a working relationship with nursing homes; this last month only 43 percent had. We have almost cut it in half. So the disillusionment of nursing homes seems to have affected the medical schools' working relationship.

In light of those findings and Dr. Butler's comments, would you further expand on your statement that all U.S. medical schools are effectively providing education about aging?

Dr. COOPER. I said the statement is "the process of aging," and this has to do with the biomedical relationship of the living systems in aging. In the testimony I pointed out that we are not, in my view and, I think, in the view of most schools, providing adequate opportunity for students to understand aging patients. However, these are very specific opportunities for students to understand the process of aging, and that is woven through all of the basic science areas of medicine in which one does consider the effects of aging upon the living process in all living matter.

GERIATRIC "ELECTIVES" INCREASE

Now, with regard to the development of specific specialty tracks or specific courses in geriatrics, the AAMC publishes annually a curriculum directory, and the last directory indicates that 45 schools now offer electives in the field of geriatrics. This is up from 32, 1 year ago. In other words, we had an increase of 13 schools in 1 year. This is in spite of the fact that the medical schools, with their financial stringencies, certainly are not in the mood, nor are they able, to consider expanding programs or developing new programs. The real direction of their efforts is to stay afloat.

I think that this change has been remarkable, but we do have coming into the medical centers a large body of elderly patients. Many of them cannot afford to go any place else, and they come to the teaching hospital as the only place where they can receive care. I think we have not adequately treated them clinically.

The things that I pointed out that have prevented the development of adequate ambulatory care, not only for geriatric patients, I might add, but for patients of all ages, relate to the difficulties we have in getting reimbursement, not only for the care delivered in those settings but also for the education and training of students in those settings. I would hope that we can get that corrected so that the schools can undertake the kinds of programs which I think many of them are interested in taking and promoting if they have the financial backing to provide them.

Fortunately, this bill on the Institute of Aging will provide some short-term support for these kinds of programs. Unfortunately, we do not have the guarantee of any long-term support and schools have become very wary of taking on a program which is supported for 2 or 3 years and then is no longer supported because of lack of funds. We have had one example after another of this in legislation passed by the Congress over the past 5 years.

Senator PERCY. I would not want to assume full responsibility for that, but I can recognize the problem involved.

I would like to rephrase my question then, possibly in this way, to give you a chance to attack it from another standpoint. It has been stated that the major goal of the medical school is to provide a model of principles and practices of medical care so that the student receives a basic understanding of patients as total human beings. Now taking the elderly as an example, how are elderly persons dealt with in this model of principles and practices where you look at the elderly person as a total human being and how is this transmitted by medical schools to students today?

Dr. COOPER. I think that varies, as I tried to point out, from school to school. In some cases, as has been pointed out with the 45 schools which actually have electives in geriatrics now, they do present a concentrated program dealing only with the aged in the total scope of their problem. In other institutions it is felt that this same approach should be introduced in each specialty which deals with patients of all ages, and there is not the feeling that you need a special department or a special course. These are the two polarized views about how the care of patients of whatever age should be considered in the medical school curriculum.

VOLUNTEER TEACHERS IMPORTANT

With regard to the statement that the residents do all the teaching, I think that the residents are important in the total teaching process, but nevertheless the substantial full-time faculty and those who support the schools in their volunteer faculty appointments are also extremely important factors in the educational process. They always have been important, and they continue to be one of the major sources of the education and training of students. If we do have physicians that are oriented and sensitive to the problems of the aged, I think that this is transmitted to the students through the clinical clerkships which all the students engage in at every medical school in the country and through the residency programs in internal medicine and the variety of specialties.

Senator PERCY. Thank you very much, Dr. Cooper.

May I remind our audience that if you have questions, we would like to have your questions so we can cover as many as we possibly can. Pass them to the aisle and a member of the staff will pick them up.

Dr. COOPER. Senator, before we close, may I just give one example of a situation in your own State?

Senator PERCY. Very briefly.

Dr. COOPER. Rush Medical School, which I know very well, has just completed a $10.5 million facility which will provide a very innova-

tive approach to geriatrics, as will other schools I have listed in the written testimony. This is going to provide not only extended care facilities but actual apartments for elderly persons who wish to have the reassurance of living nearby to a medical center. This is going to be a very important facility at Rush, not only for the care of the aged, but for the educational programs both at the undergraduate and graduate level. I think this indicates the kind of innovative approaches that the medical schools have taken relative to geriatrics.

[The prepared statement of Dr. Cooper follows:]

PREPARED STATEMENT OF DR. JOHN A. D. COOPER

Mr. Chairman and members of the committee, I am Dr. John A. D. Cooper, President of the Association of American Medical Colleges, an organization established 100 years ago to represent a constituency now composed of the Nation's 117 medical schools, 400 of its major teaching hospitals, and 60 academic societies reflecting the concerns of the faculties of the medical schools. The association appreciates the opportunity to present its views as you consider the problems of the health care system in relation to the elderly. Your invitation requested that I focus my remarks on the place of geriatrics in the medical school curriculum, and on some of the problems that medical schools face in trying to accord geriatrics and gerontology appropriate emphasis.

This I shall attempt to do. It is important to recognize that no organization, including the Association of American Medical Colleges, has control over the curricula of medical schools. General guidelines on the educational programs are provided by the accrediting body, the Liaison Committee on Medical Education. Detailed specification of curriculum content has fortunately been avoided, since that process tends to impede innovation and to construct an inflexible program of instruction not responsive to advances in medicine, in medical science, and in new patterns of medical service. The Association of American Medical College's Curriculum Directory, published annually for the last 5 years, records the dynamic flux in the instructional offerings in the Nation's medical colleges that this wise policy has permitted and a perusal of its pages will attest to the wide range of variation and the lively pace of change in curricular structure within these institutions.

The strength and excellence of American medical education is due in large part to the great diversity and individuality that characterizes the academic institutions that educate physicians. The medical schools vary in age, sponsorship, tradition, and goals. Many have assumed the coloration and perspective of the region of the country in which they are located, while others have remained cosmopolitan and national in outlook. Some schools draw their student bodies from their own locale and have populated this same area heavily with their graduates; others have sought matriculants from every State in the Union and have seen their graduates scattered through the length and breadth of the land. Some have hewn strictly to traditional disciplines, fields, and specialties while others have been innovative in creating new interdisciplines, new modes of approach to the delivery of health care, new concepts of medical education and service. In different ways, each has made important contributions to better medical care through its education, research, and service programs. Thus, it is to be expected that the schools would have responded in a variety of ways to the unique and growing challenge presented by the Nation's aging population.

THE TASK OF THE MEDICAL SCHOOLS

A brief comment on the essential characteristics of this 20th century challenge and the task it presents to medical education seems in order. Aging is an inevitable, natural phenomenon. In advanced societies, however, life expectancy has almost doubled in the 20th century and the absolute numbers of individuals living beyond the age of 65 has increased very substantially. The social welfare programs initiated in Europe at the turn of the century and several decades later in the United States did not include such longevity in their planning assumptions. Thus, the realities of the aging population are inducing major perturbations in the structure of all advanced societies. One consequence is a growing concern for how to provide the medical services needed by the

ever-increasing number of citizens who are now living beyond the age of direct participation in the daily activities which engage those still considered in the mainstream.

Timely and appropriate medical service for those who have reached 65 and older is imperative; the provision of social and family services for the elderly is of equal importance. The task of the academic medical centers in preparing physicians to assume their appropriate responsibilities for these services is three-fold. Medical students must be educated:

(1) To understand the normal aging process. Conceptually, this is best approached as part of the study of growth and development.

(2) To diagnose and care for the diseases most likely to impair function and threaten life in the elderly.

(3) To adjust the provision of medical services toward the effective management of chronic disease over long periods. This means a shift away from a principal focus on acute disease and short-term care and toward greater attention to the social and economic environment of patients who must necessarily adapt to living with disabilities.

Within the limits of present knowledge about the aging process, it is possible to educate students about the nature of aging, either through special courses on this subject or in a sequence of courses in which growth, development, and aging are interwoven. While the degree of emphasis differs from school to school, education about the aging process is provided effectively in all U.S. medical schools.

Additionally, elderly patients with acute illness are commonly encountered in teaching hospitals, and demonstrations and instruction on the diagnosis and treatment of these illnesses, with a special focus on the character of their manifestation in the elderly, is a commonplace occurrence in every school and every teaching hospital.

The principal problem area in educational and learning opportunity in our academic medical centers is in the long-term management of chronic, only slightly disabling, conditions in patients who are outside the mainstream of contemporary society. In this domain, the medical schools have selected a wide variety of approaches.

Undergraduate Medical Education and the Elderly

Some schools have directed their approach toward integrating instruction about the medical problems of the elderly into conventional course work. "Integrationists" view the process of aging and the diseases of the aged as parts of a continuum; thus, both undergraduate and graduate medical students have highlighted for them the special features characteristic of the elderly in relation to the phenomena described in discipline or systems oriented courses and demonstrated in clinical exercises. At the opposite pole, other schools have undertaken to establish organizational units in gerontology and have developed instructional offerings in geriatrics. "Separatists" view the problems of the elderly either in health or disease as unique enough to warrant attention by special discipline; hence, the impetus to create departments of geriatrics, residencies in geriatrics and a certifiable specialty of geriatrics.

In a presentation such as this, it is difficult to describe in a totally coherent fashion what is happening in schools which have taken the integrationist attitude, since attention to the problems of the aged is interwoven throughout every aspect of the student's educational experience from basic science instruction in such disciplines as anatomy, biochemistry, genetics, etc., to each and every medical and surgical subspecialty. However, I would like to devote a few minutes to a brief report on some of the activities underway in several medical centers in order to give you a flavor of how the schools are responding to the problems of tonight's hearing.

(1) At the present time, 45 schools offer electives in the field of geriatrics, up from 32 1 year ago.

(2) At the Medical School of the University of California, Los Angeles, instruction in geriatrics takes place at all levels of basic and clinical science. In addition, the medical school has active teaching affiliations with the geriatric wards in each of the two of the V.A. hospitals in Los Angeles. In one, a continuing care program for the elderly employs the same personnel who cared for patients while hospitalized to continue to care for them after they have been transferred to nursing homes. The Geriatric Research, Education, and Clinical

Center at UCLA conducts research in the area of immunologic aging, and operates an education program in conjunction with the department of medicine for training students, residents, interns, and paramedical personnel.

UCLA is scheduled to open an outpatient clinic this fall, designed for patients 65 years of age and over in need of psychosocial care. This will be operated by the family practice division of the department of medicine.

In July 1977, UCLA will open a 21-bed inpatient ward for patients over 65 in the neuropsychiatric institute. This will serve as both a teaching program involving the departments of neurology, medicine, and psychiatry, and a research institute focusing on the psychiatric disorders of the elderly.

(3) At the Medical School of Case Western Reserve University, students may elect to study geriatrics in first year courses and fourth year clerkships. Examples of the first year courses in the area of the physiology and pathology of the aging are "Rehabilitation of the Aged, Disabled, and Chronically Ill," and "Inherited Defects of Nucleic Acid Repair in Cancer and Aging." Case Western Reserve Medical School is affiliated with both public and private hospitals which have combined geriatric and chronic disease units to which students are exposed as part of the physical diagnosis course. The medical school is also being funded by a grant from the Cleveland Foundation to study the British approach to geriatrics and its applicability to the United States. The basic difference between the approaches in England and the United States to the treatment of the elderly is that in the United States the tendency has been to serve the aged by admitting them to hospitals and/or nursing homes, whereas in England the basis for patient management is the day hospital. As a result of this grant by the Cleveland Foundation, the day hospital concept is under consideration at Cleveland Metropolitan General, one of the major teaching hospitals affiliated with Case Western Reserve.

(4) At Michigan State University School of Humanistic Medicine, geriatrics is a major component of a medical school curriculum which emphasizes an interdisciplinary approach to teaching with a major emphasis on the social and behavioral sciences. Geriatrics is found in this medical school's curriculum in three places: the teaching of geriatrics is one of the major objectives of the first year program which is a focal problem sequence; during the second year, students concentrate on human biology and behavior, with 3 weeks of that component devoted to the biological and developmental aspects of aging; and all students participate in a 12-week introductory experience, immediately preceding the 2 clinical years, entitled "Fundamentals of Patient Care," which includes a series of small group seminars, two or three of which are devoted to problems of the aged.

(5) The Medical School of Duke University approaches the teaching of geriatrics by integrating it into the entire curriculum. This is done by conducting a part of the teaching of students and residents in nursing homes and retirement communities. Both family practice and senior psychiatry residents spend part of their residency in nursing homes. In addition to dealing with problems of the elderly in all courses, all students are required to take a geropsychiatry course entitled, "Mental Illness in Late Life," in which emphasis is placed on depression, hypochondriacal reactions, and psychological reactions to pharmacologic agents.

(6) At the University of Washington School of Medicine, two courses are required of all students which focus on the problem of the geriatric patient. One course is the "Ages of Man," a biological and behavioral course which is a collaborative effort between the departments of pediatrics, medicine, and psychiatry; this approaches aging as a developmental process. The second required course is "Introduction to Clinical Medicine" which, while not specifically a geriatrics course, is concerned with a variety of cognate issues including the care of the dying patient. In addition to the two required courses there are spot lectures in geriatrics throughout the curriculum as well as electives offered in the division of aging and geriatric psychiatry and the soon-to-be-created division of gerontology of the department of medicine. The University of Washington operates a geriatric research and education center in conjunction with the VA hospital; this unit directs its attention to teaching and clinical care in dementia. The University of Washington approaches geriatrics on a multischool basis and thus has collaborative programs with the schools of social work, nursing, and dentistry.

The Association of American Medical Colleges is convinced that while many of the Nation's medical schools have felt it more appropriate to address the prob-

lems of the aged developmentally, to view aging as part of the growth and development process, and to focus on the unique characteristics of each disease when manifested in the aged, the education of students at institutions that have taken this stance is just as complete and comprehensive as that received by students attending institutions where geriatrics is treated as a separate discipline. No objective evidence exists to indicate which outlook on the problem is likely to result in better and more sensitive care for the elderly.

Graduate Medical Education and Professional Practice

Despite some recent trends in curricular evolution to emphasize "tracking" in undergraduate medical education, specialization is essentially a phenomenon of graduate medical education. And just as there is variety in the ways that undergraduate medical education has responded to the unique challenges presented in the medical care of the elderly, so also have there been wide differences in approach at the graduate level, subsequently reflected in professional practice patterns.

Some physicians view geriatrics as a distinct specialty, warranting specific residency training programs and subspecially recognition while others think that it is orthogonal to all specialties and that the aged will receive better care if all appropriate specialists participate in their management. Since the AAMC does not now directly participate in the process of the creation of new specialties, this organization's preference on whether geriatrics should be a separate specialty is an academic question.

Underdeveloped Educational Opportunities

In teaching students about the problems of the elderly, it is difficult to isolate the medical from the closely interrelated economic and social needs of this group. Furthermore, the interactions of these variables becomes increasingly complex as the elderly population expands. Dr. George Maddox, director of Duke University Centre for Aging and Human Development, in describing the size of the task ahead in a recent issue of Annals of Internal Medicine, said, "Long average life-expectancy, a distinct achievement of modern societies, has proved to be an embarrassment and a current threat to existing institutional arrangements, not only for health and welfare, but also for income maintenance, transportation, housing and education. Medical education and health delivery systems in both countries (England and the United States) were designed for acute, not chronic, illness; they are therefore mismatched with the particular needs of older persons for preventive, primary and long-term care. . . . The mismatch is troublesome in the United Kingdom and dramatic in the United States." Thus, greater attention must be given to educating students in an understanding of the social milieu of the elderly. This requires emphasis not only on disease processes but on the management of the patient's social adjustment problems, an objective not easily achieved unless the medical student has the opportunity to see the patient outside the hospital setting. To truly comprehend the environment in which the elderly often reside, medical students need to spend more time in nursing homes and in ambulatory care setting, experiences that are available to a limited extent at this time.

The Importance of Research

Debate on the technical and policy issues related to the creation of a specialty, and on the appropriate approach to teaching geriatrics should not be allowed to obscure the very basic reality of how extraordinarily limited the body of knowledge about gerontology actually is. To achieve meaningful and significant solutions to this set of problems, greatly increased energy and effort must be committed to research in gerontology and a far larger fraction of the Nation's most creative aspirant scientists must be trained in this area of medical science. It is only through research that we can ever hope to understand and to solve some of the intractable problems that are unique to the aged, and to make this segment of life both healthy and productive. It is only through research that the question of whether the limit of life span is really close to the biblical three score and ten can be explored. The association, therefore, strongly supports a rapid build up of resources for the National Institute of Aging, and feels that its broad charter, which includes research in the social and behavioral as well as the medical aspects of aging, is most appropriate.

THE FUTURE OF MEDICAL EDUCATION IN RELATION TO THE ELDERLY

In the opinion of the Association of American Medical Colleges, medical educators are keenly aware of the dimensions of the educational challenge presented by the medical care problems of the elderly, and are generally responding effectively by developing a variety of educational approaches for undergraduate and graduate programs. The efforts of pioneers are under study or in the process of being adopted in the schools whose efforts to date are somewhat modest. In other schools with highly developed programs, additional innovative efforts are in experimental stages.

No absolute barriers to providing the minimally required educational experience exist and there is every reason to believe that every graduate of U.S. medical schools will soon have been exposed to the basically essential education experience.

That medical schools could do more is undeniable, particularly in terms of student-patient encounters in ambulatory settings, nursing homes, and extended care facilities. The major obstacle to this relates to the problems of financing both undergraduate and graduate medical education. Ambulatory care teaching has presented the Nation's medical schools with particularly serious financial problems. A large number of outpatients have inadequate medical care insurance or are totally uninsured. Those with coverage are often unable to pay deductibles and coinsurance. Moreover, some coverage, such as medicare, reimburses on a scale often well below customary and prevailing and excludes from reimbursement under "Part A" the costs of the education of interns and residents in out-patient facilities. Finally, when the education of students and residents is coupled with patient care, inefficiencies are introduced that increase unit costs and prevent a high volume flow of patients. All of these factors summate in a situation in which the ambulatory care services of our teaching hospitals are incurring substantial fiscal losses and will not be able to significantly expand their ambulatory educational and service programs without adequate reimbursement for them.

Thus, development of optimal pedagogic programs must await the day that medical education is on a more sound financial basis. Valuable interim assistance will be provided by the special project grants for undergraduate and graduate education in areas such as family medicine, general pediatrics and general internal medicine, authorized in the Health Professions Educational Assistance Act of 1976 signed yesterday by President Ford, especially in making possible high quality ambulatory care education for students and residents. But all medical care programs proposed in the future must reimburse the costs of educating the health professionals essential to provide the needed services, if the advances of medical science are to be brought to the beneficiaries of the programs.

In summary, the association fully supports efforts to improve education for providing the teaching of first class medical services for the elderly in the Nation's medical schools. The efforts of the medical schools can and will improve immensely as the body of knowledge of gerontology, which is now woefully inadequate, increases through research, and the financing system is modified through legislation to place undergraduate as well as graduate medical education on a solid financial basis.

Senator PERCY. We are very happy to have Sister Marilyn Schwab with us who is a registered nurse and administrator of the Benedictine Nursing Center in Mount Angel, Oreg. Sister Schwab has had special training and experience in geriatrics and formerly was the chairperson of the Committee on Skilled Nursing Care of the American Nurses Association. Sister Schwab helped to develop the American Nurses Association's report for the Senate Committee on Aging which describes problems of providing skilled nursing as presently defined by medicare and medicaid, problems relating to alternatives to institutional care, problems with supply and training of qualified personnel, and methods of reimbursement for quality care.

STATEMENT OF SISTER MARILYN SCHWAB, R.N., ADMINISTRATOR, BENEDICTINE NURSING CENTER, MOUNT ANGEL, OREG.

Sister SCHWAB. Thank you, Senator.

I have been asked to speak this evening from my viewpoint as a nurse about my experience of medical care of the aged, some thoughts about training needs in geriatrics in medical schools and about the influence that medical training has had on the profession of nursing.

It is not a new concept for this audience that health care of the elderly has to be delivered in a manner that deals with multiplicity and interrelated aspects of the elderly person's emotional, cultural, and economic problems, as well as his diseases and disabilities.

The implication for education that flows from that concept tends to support the notion that perhaps each health discipline needs to educate its practitioners to approach the elderly from a broad psychosocial-medical kind of framework. However, given the brief history of the science of gerontology and the relatively undeveloped stage of its application to the health sciences, it would seem more useful for each discipline to focus primarily on its unique contribution to the health care of the elderly.

Medicine needs to further develop and teach the medical aspects of the health care of the aged—that is, the diagnosis and treatment of disease—and at the same time medicine needs to teach its practitioners to understand and collaborate with other health care disciplines, not just to carry out their proscribed medical regimens, but to share an interdisciplinary assessment, planning, intervention, and evaluation process so essential to total health care of the elderly.

My experience with medical care of the elderly is that the interests and diligence in diagnosis and treatment has less to do with the chronological age of patients being treated than it does with the complexity and apparent hopelessness of the problems presented. The combination of old age and multiple health problems tend to cause frustration and a feeling of helplessness in the physician as it does in many other professions.

A serious problem in medical care is the apparent compulsion of many physicians to treat once a condition has been diagnosed. Doctors need to become comfortable with a patient's right to refuse treatment at the same time he recognizes the right of the patient to full information—that is, to a good diagnosis. Too often physicians are uncomfortable about making overt decisions not to treat and so they choose a route of what a physician friend of mine calls "benign neglect"; that is, "If I don't prove he has it, I don't have to feel guilty about not treating him."

We need to train physicians to make a good diagnosis on elderly patients and then be a part of good decisionmaking processes with patient and family regarding treatment or nontreatment. This demands some serious reexamination of our values and ethics and something we need to work on together.

THE ROLE OF NURSING

I would like to comment briefly on the role of nursing and its relationship to medical care of the aged. A large portion of those services

that are commonly classified as medical care services to the elderly are in fact nursing services, but the general public and other health provisions of the health disciplines still seem to see nursing only as the adjunct to medicine.

Indeed our justification for reimbursement for nursing care under medicare and medicaid, for instance, is almost always linked directly to a medical diagnosis and the need for a medically delegated service. Nursing, however, is a distinct art and science dealing primarily with the caring aspects more than the curing aspects of health care. Nursing skills are directed to assisting a person to cope with the effects of disability and disease. Nurses deal with things like immobility, confusion, discomfort, and isolation problems so prevalent in the care of the sick elderly. Nursing is also directed toward keeping people well, especially people at high risk such as the ambulatory elderly. Long-term care, whether in an institution or at home, and preventive and health maintenance services are two major kinds of needs of our elderly population, and nurses are a major underutilized resource in meeting these needs. Nurses are needed not just to extend the role of the physician but to complement medical services by providing equally important nursing services to the end that all the health needs of the elderly are served. All of the other health and social services disciplines also have special contributions to make, and together we need to learn what collaboration really means so that elderly people really see integrated, coordinated, interdisciplinary health care.

Senator PERCY. Sister Schwab, in the hospitals and nursing homes that you have encountered and worked with, how much influence do doctors have on the nurse's care of the elderly patient?

Sister SCHWAB. Well, the physician has, of course, a great deal of control in the acute care setting, particularly because it is related to the nature of the care which an individual in an acute care setting is there for, diagnosis and treatment of a condition—usually a particular condition. Long-term care, however, presents different kinds of treatment. They are receiving nursing homes or home health services for multiple reasons that may be social, psychological, economic—maybe the fact that there is no one at home to care for them.

Under present reimbursement situations in medicare and medicaid, it is very much tied up with what the physician says may not be done, so that what nursing services are performed must be ordered by the physician.

NURSE GERIATRIC TRAINING

Senator PERCY. Where do most nurses today receive their geriatric training—in special training programs, exposure to the elderly patients or, in your judgment, do they receive any special training at all?

Sister SCHWAB. Nursing schools are probably not that much better at giving geriatric exposure to geriatric and gerontological nursing than medical schools, though I think they are doing a better job. I cannot really speak with any great authority on the schools of nursing across the country, but I am aware that, for instance, the American Nursing Association is in the process of doing a survey of the content of the programs in nursing throughout the country. That data will be

ready soon as to how much is really being taught and where it is being taught.

There is an increased amount in the curricula about care of the aged. We also have a growing number of advanced practice kinds of programs concerning nurse practitioners. There is something like seven or eight programs that I am aware of and they are developing nurse practitioners around the country for care of the elderly. There are about seven or eight graduate schools that are teaching nursing in gerontology and geriatrics.

Senator PERCY. The committee has not surveyed U.S. schools of nursing since 1971 and I wonder, statistically, if you could update us now or help us get information as to what progress it has made since then. In 1971 we found that only 27 of 512 schools that responded to the survey actually had a program of geriatrics in their curricula. Do you know if there has been improvement since that time?

Sister SCHWAB. I am sure that there has been. There has been a great deal of activity in the last several years. We could see that you would get the information from the American Nursing Association's survey which is in progress. After gathering some initial data about how many schools offer anything in geriatrics, the study goes into a second phase, looking at where it is being offered, who is teaching it, what is the qualification of the instructor, and so forth.

Senator PERCY. Finally, you mentioned collaboration in your testimony. Our staff would like to know, do you know of any schools of nursing or medicine which are working toward collaboration?

Sister SCHWAB. I cannot cite you any, but that certainly does not mean that they are not. There are probably people in this audience that can give you some examples.

[The prepared statement of Sister Schwab follows:]

PREPARED STATEMENT OF SISTER MARILYN SCHWAB

I am grateful for the invitation to testify before this committee, as a nurse, on the topic of medical care of the aged and education in geriatric medicine. I speak from 15 years' experience of nursing in a nursing home, plus the opportunities afforded me in the past 4 years as the chairperson of the Division on Gerontological Nursing Practice of American Nurses Association. In the latter position, as well as during frequent lectures and workshops with nurses, I have been in contact with hundreds of nurses who work with the aged in all parts of the country, and have listened to their concerns. I hope my words can faithfully reflect the concepts and concerns of those colleagues, as well as my own.

I have been asked to speak from my personal experience of the quality of medical care of the aged, and to submit ideas about the training needs in medical schools on the subject of geriatric care. I have also been asked to reflect and comment on the relationships of medicine and nursing and how educational and practice trends in both disciplines have affected one another.

First, I would like to make a clarification between "medical care" as the diagnosis and treatment of the disease and "health care," which implies something much more inclusive and which deals with an individual person in relation to his total health and well-being. It is not a new concept, especially to this audience (the Gerontological Society) that health care of the elderly has to be delivered in a manner that deals with the multiplicity and interrelatedness of the elderly person's problems—emotional, cultural, economic—as well as his diseases and disabilities. Thus, to speak of "medical care" in isolation from other health care problems presents a woefully incomplete picture of the elderly person. To teach practitioners about medical care in isolation from other health care needs can lead to fragmentary and distorted understanding of the patient.

It would seem then, that each health discipline (in this case, medicine) should ideally educate its practitioners to approach the aged from a broad psycho-social-medical framework. However, given the brief history of the science of gerontology and the relatively undeveloped stage of its application to the health sciences, I believe it is important for each discipline to focus primarily on its unique contribution to the health care of the elderly. In other words, medicine needs to further develop and teach the medical aspects of health care of the aged—that is, the diagnosis and treatment of disease entities.

At the same time, medical schools need to teach future practitioners to understand and collaborate with other health care disciplines, not just to carry out their prescribed medical regimens, but to share in the interdisciplinary assessment, planning, intervention, and evaluation process, so essential to total health care of the elderly. We need more physicians who understand medical problems of the elderly, more geriatric medical specialists, and especially we need physicians who understand that nurses and social workers and physical therapists and many other disciplines have important contributions to make to the health care team which serves the patient together.

Medical schools need to examine values taught, in light of the challenges presented by an aged population. One such challenge is the question of how much, or whether, to treat a particular problem at a particular point in the older person's life. My experience with medical care of the elderly is that the interest and diligence in diagnosis and treatment have less to do with chronological age of the patient than they do with the complexity and apparent hopelessness of his presenting problems. It is the combination of old age and multiple health problems that tends to cause frustration and a feeling of the helplessness in the physician. In these situations, difficult ethical dilemmas are often posed. Principles of patients' rights and informed consent, as well as judgment about the relative value of treatment are frequently severely put to the test.

I feel many physicians have an apparent compulsion to treat any condition they diagnose. Too often, because they are uncomfortable about making overt decisions not to treat, they choose also not to diagnose. "If I don't prove he has it, I don't have to feel guilty." Physicians need to be taught to be comfortable with a patient's right to refuse treatment, at the same time that he recognizes the right of the patient to full information—that is, diagnosis. Elderly people, especially in nursing homes, are still put off with the excuse that almost any complaint is "due to old age," are rarely given the benefit of a good diagnosis, and even more rarely given the real opportunity to make a good decision with their physician and their families about when to treat or not treat. This demands some reevaluation of traditional ethical values in medicine.

Finally, I would like to comment on the role of nursing in relation to medical care of the aged. A large portion of those services commonly classified as medical services to the elderly are, in fact, nursing services. But the general public and other health disciplines too often see nursing only as an adjunct to medicine. Indeed, justification for reimbursement for nursing care is almost always linked directly to a medical diagnosis and the need for a medically delegated service. However, nursing is a distinct art and science dealing primarily with the "caring" more than the "curing" aspects of health. Nursing skills are directed to assisting a person to cope with the effects of disability and disease. Nurses deal with immobility, with confusion, with discomfort and isolation, problems so prevalent in the care of the sick elderly.

Nursing practice is also focused toward keeping people well, especially people at risk, such as the ambulatory elderly. Long-term care and restoration, whether in institution or at home, and preventive and health maintenance services are two important kinds of health care needs of the elderly, and nurses are a major under-utilized resource in meeting those needs. Nurses are not needed just to extend the role and services of the physician, but rather to complement his services, by providing equally important services that meet the health needs of the elderly. We must stop talking about extending the services of the physician and begin to recognize other health care disciplines as having useful and special services to offer. We must create a health care system that integrates those services in a collaborative manner rather than in our present hierarchical system. Collaboration implies autonomy of the individuals who collaborate. Thus, nurses in recent years are assuming more responsibility and accountability for their own decisions and treatments of patients.

State nurse practice acts are being revised to give legal recognition to the nurse's autonomous functions. This trend must be supported and one important way that is done is through recognition by third-party payors of nursing services as a distinct benefit. As long as medicare and medicaid benefits are related solely to medical diagnosis and medical services as defined only by a physician, the health care needs of the elderly will continue to be only partially met.

Thank you for the opportunity to share these concerns with your committee.

Senator PERCY. Thank you very much indeed, Sister Schwab.

Dr. Robert W. Berliner is dean of the Yale University School of Medicine. Prior to his appointment as dean, Dr. Berliner was Deputy Director for science at the National Institutes of Health. Prior to that position he was Director of Laboratories and Clinics at the National Institutes of Health. Dr. Berliner is a graduate of the Columbia University School of Medicine.

Dr. Berliner.

STATEMENT OF ROBERT W. BERLINER, M.D., DEAN, YALE UNIVERSITY SCHOOL OF MEDICINE, NEW HAVEN, CONN.

Dr. BERLINER. Thank you, Senator.

You have asked that I focus my attention on what I perceive to be the place of geriatric training in the education process, and specifically you asked me: Should the science of the aging process be concentrated upon during the basic science classes, during clinical studies, during special programs which many medical school curriculums have implemented, or during the years of internship and residency— or should the aging process be given specialized attention at all?

To the first of these questions I would respond: All of the above. That is, assuming that we mean more than just the science of the aging process, but mean to include the effects of aging on people, the interaction of aging with disease processes, and the medical care of aged people, there is something there for every stage of medical education. To the extent that we know anything about the aging process itself, it clearly belongs in the basic science curriculum; unfortunately we know very little about the fundamental nature of aging and it would be an unusual school that devoted a great deal of time to aging at that level.

I would expect the medical student to learn a great deal about the effects of aging upon disease processes during their clinical studies. Indeed, with the increasing age of the patients that students are exposed to, they can hardly avoid the opportunity to learn about age and its diseases, although some may profit more than others from the exposure. And finally, in my opinion, learning how to take care of aged people belongs in the post graduate period of residency.

In what I have said so far, however, I think I have avoided the question that is the real focus of this hearing, because what I have said could have been said equally well about any other process or group of diseases. What I have said merely describes the general organization of the medical curriculum. I think the important word is found in your second question, "Should the aging process be given 'specialized' attention?" and my answer to that is a qualified "no."

The diseases that are the causes of illness and death in the aged are the same as those that begin to appear in people in their thirties and

forties. There is no distinct group of diseases that occurs exclusively in older people. They have the same diseases as younger adults. The greatest difference is that they have them much more often. Of course it is also clear that the effects of the process of aging modify the way in which the individual responds to the stress of disease. The interaction of aging and illness can hardly escape the attention of any reasonably sentient student of medicine since the aging make up such a large fraction of the population who seek help in our teaching institutions, but I do not believe that this interaction of aging and illness, which is so much a part of everyday medicine, is a matter that requires separate and specialized attention.

Aging Process: An Enigma

Although I do not believe that geriatrics or gerontology warrant a special place in the medical curriculum, this does not mean that there are not a number of aspects of the aging process and of the effects of aging on people that call for serious investigative attention. Fundamental to all is a better understanding of the aging process itself. Unfortunately, perhaps because we do not yet have an adequate picture of the normal state, we do not really have an adequate theory of what aging really is. When we do, we will perhaps detect a more consistent basis for those changes which we recognize as the accompaniment of aging—changes in almost every organ system that have striking effects on the interaction of the individual with his environment and with the stress of illness.

Lack of this fundamental understanding, however, should not prevent a more direct approach to some of the practical problems, both physical and behavioral, some of which have been mentioned this evening. For example, to changes in immunocompetence with age and its possible relationship to neoplasia and to degenerative disease; the change in pharmacokinetics with age that may yield paradoxical effects of drugs in the elderly; or the basis for the doubled death rate in the newly widowed elderly. There is no lack of important investigative problems relating to age and aging.

Setting these matters aside, however, I would like to express my concern over one word that appears in the title of this hearing. The word is "neglect." My concern arises not from the conjunction of the word "neglect" with the subject of aging but from the further implication of the field of medicine. Clearly there is in our society a deplorable neglect of the aged. They are often excluded from the family, from participation in many aspects of life, and often relegated to institutions that are among the most disgraceful of our society. The use of the word "neglect" in this connection understates the case, but I am disturbed because the content in which the word appears suggests that in some way medicine is an important party to this neglect and is going to be called upon to provide the solution to this problem.

Perhaps I am taking an unnecessarily paranoid point of view and, by the time I deliver this testimony, my concerns will prove to have been groundless and this issue a strawman. But we have many precedents. Because of social and economic forces there are among our people, to say nothing of the rest of the world, many who are malnourished. But faced with the overwhelming problems of providing

adequate food, we decide that what is needed is intensified efforts in the science and teaching of nutrition.

There are many things that adversely affect the well-being and, more narrowly, the health of our people that are quite beyond the capacity or even the mission of medicine to control. Statistics relating to the health of our population are much more affected by the fact that people, eat, drink, and smoke too much and drive like fools than by what doctors can and should do. As doctors we should certainly be concerned about such matters, but we shouldn't be expected to provide the solutions. Similarly it is not going to be within medicine that we find the solution to the neglect of the aged. In short, although aging and the aged constitute serious societal problems, I do not believe they are neglected in either medical education or medical care.

Thank you.

Senator PERCY. Doctor, would just the fact that the treatment of the aging is a postgraduate course generally make it look as though, then, it is an appendage and not a real course subject?

DR. BERLINER. I was not suggesting that the teaching of aging should be a postgraduate course. What I was saying is that learning to take care of specific kinds of people, how to do it, belongs in graduate medical education rather than the undergraduate medical education, and not only aging but with everything else the doctors do.

Senator PERCY. In day-to-day contact with the faculty and students at Yale, do you find an earnest interest and desire for knowledge in the geriatric field? Be very frank.

Dr. BERLINER. As a particular field specialty, no, I do not.

Senator PERCY. It is my understanding that Yale is one of the several medical schools participating in the National Institutes of Health program for the training of medical scientists. Could you briefly describe this program and how it operates? As a former NIH policymaker, do you find that both NIH and the medical school can benefit from this joint effort?

THE FEDERAL SCIENTIST PROGRAM

Dr. BERLINER. The Federal scientist program is essentially a program which provides simultaneous training in medicine, more or less the standard medical education, and along with that an opportunity for intensive training in, usually, one of the basic sciences on which the science of medicine is founded, such as biochemistry and so on. The student obtains both the M.D. and Ph. D. during the period in which he is enrolled in this course, which is usually 6 years. I think it is an excellent way of providing the people who are going to do much of the basic research that is closely related to medicine itself. I think that the medical aspects of the education gives an orientation to the scientist which many people without such training do not have.

Senator PERCY. Does the National Institute on Aging participate in this program and, if not, do you see any potential for future cooperation?

Dr. BERLINER. The program, as far as I know, is entirely supported by the Institute of General Medical Sciences. It is a noncategorical sort of program and the Institute of Aging is a noncategorical insti-

tute. I suppose there is a possibility that they could get involved in it, but I don't know that the stage in which students enter this program that they would have an idea of commitment to work on aging. This would probably not apply to students in the junior year or the senior year in college which I think, is too early for them to get committed to a field such as gerontology.

Senator PERCY. More and more medical schools are developing ties with their community health clinics and home care organizations. Can you describe Yale's effort in this area and whether the elderly patient receives attention?

Dr. BERLINER. Yes; in New Haven there are several. There is one major community center, the Hill Health Center, which is actually sponsored and partly supported by the school of medicine in which we have a close relationship with members of our faculty involved in the care of the people. They take care of a broad sample of the population, mostly of the poorer population of New Haven, including the elderly. I don't believe there is any home care involved in this particular program.

Senator PERCY. I want to thank you very much indeed for your willingness to express the points of view that are not always popular, and probably not popular with some of the people here, but I think it is provocative and helpful.

I would like to amend our format to permit anyone who might feel that someone on the panel has committed their version of the Polish faux pas to have a minute to attack one another with freedom [laughter], but we will limit it to just a minute if you don't mind.

Our next witness is Dr. Theodore Sherrod. Dr. Sherrod is a full professor in the department of pharmacology at the Abraham Lincoln School of Medicine at the University of Illinois at Chicago Circle. Dr. Sherrod has been associated with the University of Illinois in various professorships since 1940. He is a graduate of the University of Illinois College of Medicine. Jessie Sherrod, Dr. Sherrod's wife, is very active in social work in the Chicago area.

We are delighted to welcome you, Dr. Sherrod.

STATEMENT OF THEODORE SHERROD, M.D., PH. D., DEPARTMENT OF PHARMACOLOGY, SCHOOL OF BASIC MEDICAL SCIENCES, UNIVERSITY OF ILLINOIS AT THE MEDICAL CENTER

Dr. SHERROD. Thank you, Senator Percy and Dr. Binstock.

I am perhaps the least qualified of all the panelists to give my points of view regarding aging; however, I have been very interested in the phenomenon for a long time and as I get older I become more interested.

Aging is an inevitable fate of all living things. The geriatric population is constantly increasing, largely because of advancements in nutrition, sanitation, immunology, improved surgical techniques, and the effective chemotherapy of infectious diseases. Many of the so-called degenerative diseases, characteristic of the aged, are becoming increasingly more evident.

Numerous socioeconomic factors operate to preclude access of many of the aged to the kind of medical attention needed to prevent, amelio-

rate, or cure their ills. Perhaps more important, however, is the general lack of appropriate training in geriatric medicine among physicians and other health care personnel.

Geriatric Pharmacology

The field of geriatrics is, perhaps, the newest medical specialty, dealing with the oldest patient population. Training of all physicians should encompass geriatric medicine. As a pharmacologist with some knowledge of the marked difference in the response of the aged to many therapeutic agents, as compared with the young adult or middle-aged patient, it would seem advisable or desirable to have this labeled as "geriatric pharmacology," because I think there is enough difference in the response of the elderly patient to drugs to warrant this kind of special training.

There appears to be a degree of resistance by many members of the medical profession to regard the elderly patient as having medical problems more or less characteristic of that age group. It is true that while many of the diseases are the same—diagnosed by the same techniques and treated in a similar manner as in the younger patient—the rate of healing and the responses to medication in the aged may exhibit striking differences. Just as the pediatric age group have medical problems peculiar to infancy and early childhood, the elderly patient is likely to have medical problems more or less characteristic of that age group.

Aging, and the accompanying physical changes, occurs in different people at different rates and appears to be largely genetically determined. However, with age comes an increasing vulnerability to many diseases that may minimally affect the younger patient. Specific medical training in such areas should be a mandatory part of the medical curriculum.

While a department of geriatric medicine would be most welcomed and desirable, at least a division of geriatric medicine should exist in all medical schools with special emphasis on gastrointestinal, arthritic, metabolic, cardiovascular, and other diseases which so often plague the elderly. Federal and other funds should be increased to support research in geriatric medicine. Grants for such efforts should merit the status of high program relevancy. The alternative to living to the age where pain and suffering often make this an almost unwelcomed stage of life is to die young. Already much information in geriatric medicine is available. It will be applied only if organized medicine and academic medicine stimulate the needed interest in this area.

Thank you.

Senator Percy. Dr. Sherrod, how often in your normal routine, if you can call it that, as a professor of medicine are you called upon to teach about specific factors of the aging process and what does this entail?

Elderly Respond Differently

Dr. Sherrod. Just about never. However, I should emphasize the fact that in medical training we occasionally allude to the fact that the elderly patient is to respond differently because of certain path-

ological alterations that will greatly influence the way in which this patient handles drugs and we will make mention of that fact, and this is somewhat in passing. I think this attitude is almost characteristic of just about almost all people, most people below the age of 40 or 50, but once we get old we realize that there are problems that are characteristic of the aged.

What I am saying is we seem to be so youth oriented. We definitely know that there are problems that are more commonly encountered in age which I think can be handled to the extent that the elderly person could live a more peaceful existence than we make possible simply because we have not emphasized that aspect of the medical training. I am well aware of the fact that so many physicians come from medical school, go through their residency training, and are almost totally unaware, at least of the behaviors of the elderly, that we are unaware of many of their problems and get into a lot of difficulties so far as the application of drugs is concerned. Elderly patients do definitely respond differently to a large number of drugs that have so many complaints, and there may be a tendency on the part of the physician to treat every complaint as a central complaint, totally isolated from the patient with no thought of how one drug is going to react to the other. These are the kinds of things that I think ought to be taught in medical school, certainly in my profession, and be labeled "geriatric pharmacology."

Senator PERCY. As a specialist in pharmacology, do you see the need for a specialist in geriatrics, or only a specialist in pharmacology with a concentration in geriatrics?

SPECIALIST IN GERIATRICS?

Dr. SHERROD. I see the need for a specialist in geriatrics just as I see the need for a specialist in pharmacology and surgery. I think it is the recognition of such a specialty that is going to lift the thinking about the aged as having special problems. So, from that point of view I think that having a specialty with the status of some other specialties in medicine will engender the kind of support from the lay community, as well as from the institutions and what have you, so that there will be people flocking into this area as a specialty.

I think there are people—that is, people in training, medical students, and residents, perhaps interns—who have not decided where they want to go. If they see this as an opportunity that has some recognition nationally and locally, this will lift the status of that specialty, if we can call it that, and I think it should be called that.

Senator PERCY. Just to be sure I understand your view, would this specialist categorization apply to all disciplines within the medical curricula or should there be a separate and distinct department of geriatrics?

Dr. SHERROD. I certainly don't think it should involve pediatrics because I think the problems are quite different, but I think most of the problems do transcend most of the other specialties involving treatment of elderly people. There are problems that the surgeon can handle best and there are problems that the internist can handle best, and they transcend many areas.

If there were a division or a department of geriatrics, the emphasis could be placed appropriately in this area. I think one of the difficulties of not really having a specialty as geriatrics, and I think some

of the resistance so based, is because the problems do transcend so many areas.

Senator PERCY. I wonder if you could just go back into your own experience as a professional person and tell us whether you felt that you were adequately trained to deal with the elderly people in your education, or did you pick this up and develop your interest and expertise just as a matter of your own experience?

Dr. SHERROD. Senator Percy, as I said at the outset, the older I get, the more interested I become in the aged. [Laughter.]

Senator PERCY. The definition of an older person is somebody 50 years older than we are.

Dr. SHERROD. To those in their 20's, no older than 25, anybody 50 years old is really ancient. So at that time, without having appropriate leadership to stimulate them in geriatrics as a profession, we could not care less, but in all fairness to academia, occasionally statements were made to the effect that "Now when you deal with a person of this age you must look out that certain changes have occurred and that this patient requires this particular kind of procedure. You have to be careful that you don't do thus and so," but this was almost as a footnote and not as a fact.

Senator PERCY. Thank you very much indeed.

Our last panelist is Dr. Leslie S. Libow, medical director of the Jewish Institute for Geriatric Care in New Hyde Park, N.Y. He is also chief of geriatric medicine of the Long Island Jewish-Hillside Medical Center in New Hyde Park. Dr. Libow is associate professor of medicine at the Health Sciences Center, State University of New York at Stony Brook. Prior to these numerous roles he was instrumental in developing the geriatric program within the Mount Sinai Hospital Services at City Hospital Center in Elmhurst, N.Y.

Dr. Libow.

STATEMENT OF LESLIE S. LIBOW, M.D., F.A.C.P., MEDICAL DIRECTOR, JEWISH INSTITUTE FOR GERIATRIC CARE; CHIEF, GERIATRIC MEDICINE, LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER, NEW HYDE PARK, N.Y.; AND ASSOCIATE PROFESSOR OF MEDICINE, HEALTH SCIENCES CENTER, STATE UNIVERSITY OF NEW YORK AT STONY BROOK, N.Y.

Dr. LIBOW. Thank you, Senator Percy.

Senator Percy, Professor Binstock, distinguished colleagues, ladies and gentlemen, my medical work is entirely with the elderly, and I categorize myself as a geriatrician. Earlier, Dr. Butler mentioned the lack of homegrown geriatricians in the United States. Well, if I am not homegrown, I am certainly homemade. My initial training was in internal medicine at Mount Sinai Hospital of New York and in research in aging at the National Institutes of Health—the latter at the same period that Dr. Butler and Dr. Berliner were working at NIH. In the past several years, I have developed a special health care system and an approach to care exclusively focused on the elderly. This system and approach encompasses community and institutional care and is centered about a health team.

These programs served as a base for the development, at the Mount Sinai City Hospital Center in New York, of the first geriatric medical residency program in this country. We trained several geriatricians, and six more are now in training at the second established geriatric residency program, at my present campus, the Jewish Institute for Geriatric Care and Long Island Jewish-Hillside Medical Center, affiliated with the SUNY School of Medicine at Stony Brook. Those trained now lead geriatric programs in various cities; 250 to 300 other interns and residents have also been trained for 1- to 2-month periods in the discipline of geriatric medicine as a basis of whatever special area of medicine they are pursuing.

These health programs also served as a base for the teaching of geriatric medicine to medical students. These students have come to us from many medical schools, because their own schools do not offer any special courses in training in geriatric medicine.

Findings and Recommendations

The key points derived from these training experiences are as follows:

(1) Medical students have a natural and active interest in learning about and working with the elderly. My experience at three different medical schools has made this interest clear, no matter what area of medicine the student may enter later. Since my colleagues in the faculties of medicine doubt this interest, I have just completed a survey of several hundred freshman students at seven geographically and ethnically diverse medical schools to learn of their interest in this field. Of the nearly 650 students surveyed, approximately 50 percent completed and returned the questionnaire. The major questions were: Are you interested in having a course on human aging? Answer, "Yes" (75 percent). Would you take an elective in your clinical years focused on the medical and psychological illnesses of the elderly? Answer. "Yes" (75 percent).

These impressive percentages were found at all the schools and reflected the student interest at private, elitist, and State medical schools. The results speak for themselves.

(2) It is crucial to have geriatricians as role models in the medical school faculty. Physician specialists are necessary for students to identify with and to help sustain their natural interests in the elderly, in the face of the negativism toward geriatrics of the traditional faculty. Medical students will not easily identify with the social workers, economists, and psychologists who often excellently teach the few courses in geriatric medicine that now exist. We need geriatricians at every medical school and major hospital to teach the available body of knowledge known as geriatric medicine, to teach and develop the special approaches to the elderly, and to lead efforts toward furthering this knowledge and these approaches.

(3) Establish a special geriatric health care system in each medical school or hospital community and base it on a team approach. The student can then observe and participate in this approach. You can't easily teach and demonstrate human concern and clinical skills with regard to the elderly from a typically sterile classroom atmosphere.

The struggle of the ill elderly for life and self-sufficiency against the present day laissez-faire health system, must be appreciated first hand.

(4) Teach geriatric medicine in special courses and as a special discipline. The body of knowledge in geriatric medicine is vast, but usually overlooked. The 17 seminars in clinical medicine and the additional 40 individual scientific papers in clinical medicine that will be presented during the next 4 days of the Gerontological Society's meeting are but one example of this knowledge. As in all other fields, more research is, of course, necessary.

During the freshman and sophomore years, areas such as the biology, physiology, and psychology of normal aging, as well as the demography and epidemiology of late life, are emphasized. The courses and field placements should emphasize the struggle for self-sufficiency of the ill elderly, as well as the vigor of the well elderly.

In the clinical years, the student should work alongside of geriatric resident physicians in training and/or alongside of faculty level geriatricians. The clinical exposure should include areas such as frequent home visits, ambulatory care, nursing homework, and community health education. All this is part of a team of professionals, so that an appreciation develops for the need for this coordinated effort.

Physician, Patient Goals Differ

The goals of the ill elderly must be differentiated from those of the young physician. Reversal of dramatic illness is welcome at any age, but smaller, quieter victories are often paramount to the older patient while unappreciated by the young physician. The physician should also be trained in the special approaches to geriatric history taking and rapid and accurate mental status evaluation. Too often a limb is carefully evaluated and the mind is overlooked. Emphasis should be placed on appropriate dosage and interactions of multiple medications. Establishing rapport with the elderly patient and making them feel the sincere interest and concern of the physician is itself a challenge. The causes and treatment of so many common problems are different for the elderly and often cannot be usefully and safely extrapolated from the general rules for the average patient of any age. In medical school, there is constant reference to the 70 kilo man, who presumably is ageless. Examples of problems which often have different manifestations, causes, and treatments in the elderly, as compared to the middle-aged and young, are headaches, weight loss, arthritis, fevers, elevated blood pressure, cholesterol values, mental changes, use of antidiabetic tablets, treatment of cancer, et cetera.

Headaches in the elderly may be due to polymyalgia rheumatica, a problem uncommon in middle age and thus often not diagnosed in the elderly. This disease could lead to blindness or stroke if not treated properly. Decisions about treatment of elevated blood pressure, elevated blood levels of sugar or cholesterol are usually made without awareness of the specific body knowledge as it applies to the elderly. Thus, it is frequent to note lack of treatment of moderate hypertension in a 68-year-old, in spite of reasonable evidence that treatment of hypertension at this age diminishes morbidity. Also common are inappropriate treatment decisions related to elevated blood sugar and dia-

betes mellitus. There are different factors in the elderly that must be considered when deciding about treatment with diet, insulin, and/or oral hypoglycemic medication. The key factors in choice of treatment of the elderly diabetic may include subtle decline in memory, vision, appetite, or access to renewal of medications. This is in contrast to the certain factors used in decisionmaking with middle-aged patients, such as cardiovascular toxicity of the oral hypoglycemics, and the probable relationship of poorly controlled blood sugars to vascular complications occurring after many years of having diabetes mellitus. These latter factors may have a role in diabetes of the elderly, but they appear to be of secondary importance, compared to the key factors listed above.

Mental Depression of Elderly

Mental depression in the elderly is probably the most frequently overlooked diagnosis of all. When it finally is noted, it is too often treated with antidepressants at dosage levels that are correct for younger patients but toxic for the elderly. An endless number of examples exist which reflect an improper approach to the elderly.

These approaches, these facts, this sensitivity, this need for further research are not usually taught in medical school, and certainly not as a separate discipline, warranting a special approach.

(5) Establish independent full departments of geriatric medicine in all medical schools and hospitals. This special discipline needs its own identity, faculty, and budget. Otherwise, when budget and staff reductions in medical schools and hospitals are necessary, those programs dealing with the elderly are the first cut. Again, we see the prejudice called ageism at work. The environment for growth and development of this discipline will, at most, be neutral in other departments such as internal medicine. From this proposed independent department of geriatric medicine, geriatricians can affect teaching in areas such as psychiatry, family practice, internal medicine, urology, et cetera. The existing body of information, as well as the special research and clinical approaches to the elderly, must be taught to all physicians so that their approaches to the elderly will be more appropriate.

(6) Geriatric medicine must be more clearly defined though its definition will probably change with time. It is certainly a discipline of scientific and clinical facts and approaches which treats aging, late life and the elderly, as special. The geriatrician is the physician specialist in this generalist area. The geriatrician leads the development of the health care approaches in the community and institutions and leads the teaching and research efforts. The geriatrician also delivers primary care in those areas where it is particularly not being delivered—specifically, in the convalescent and nursing home area, in-home care, in organized long-term ambulatory care and, finally, as clinical consultant to patient and family who cannot obtain satisfactory response to their problems. The physician has been given the legal authority to lead the improvement of care of the elderly. We must now teach the medical student and physician to properly exercise this authority and leadership.

The issue is not one of "Do we need another specialty called geriatric medicine?" The issue is clearly that there is a group called elderly

who need special medical approaches and there are places called medical schools and hospitals that must train young physicians to meet this unmet need.

Thank you.

[Applause.]

Senator PERCY. That's one thing I like so much better here than the Senate hearings down in Washington—we just never allow applause there. [Laughter.] I am going to change the rules of the Senate; I rather like it. It is a great tribute to our panelists, I think, all of whom have been absolutely marvelous.

I would like to ask Dr. Libow a question about the research that will be reported on later this week by Dr. Shanas. She has been doing a great deal of study on premedicare and postmedicare, and her figures will show that when you take into account that there are more than twice as many housebound and bedfast people 65 and over as there are in institutions today—and this is exactly the same proportion as existed before with medicare—what are the implications for schools of medicine or the medicare program when you come to see these statistics?

Dr. LIBOW. Well, the implication seems fairly clear. A good deal of medicare money is used for the training of physicians in all specialties of medicine, but regrettably, very little is used for training geriatricians or for training medical students about geriatrics. Some of the problems of the elderly require a team approach and special community health systems and I feel a distinct clarity that a physician must be a strong part and a leader of these special programs. Such special approaches, now lacking, would reduce institutionalization and the present trend toward physical dependency and homebound status.

As a second point I feel that medicare is, in a way, an enemy of the elderly. It sounds paradoxical, but the point is clear. Medicare has made the older person a wonderful client—a client for the practitioner—and that does not include only the medical practitioner, but I say that to my colleagues in all fields—a wonderful client too, for the hospital and the nursing home. So there are many vested interests that hold on to the organ ailments of the elderly and perhaps even the bodies of the elderly without really approaching the human being.

Senator PERCY. I think you have very aptly summarized months and possibly years of hearings that we have held on this subject. We could have saved an awfully lot of research and time.

I believe you did say that you had trained a dozen geriatricians. What happens to a trained geriatrician? Are they snapped up by the medical profession for positions of responsibility? Tell us what they are doing now.

Dr. LIBOW. One of the outstanding clinical medical journals in the United States, "Annals of Internal Medicine," will be publishing an article next month from our center answering your question. I will briefly summarize that for you.

TRAINED GERIATRICIANS IN DEMAND

First of all, we regularly receive phone calls and letters from many of the people in this audience and from many deans at many medical schools asking if these geriatricians are available.

Of the 12 that have been trained, I can briefly tell you where they now are. One is now leading a geriatric program at a leading hospital and its community nursing home in the county of Westchester, N.Y. Another is working with us, expanding our program in our communities of Nassau and Queens in New York. Another has returned to Kyoto, Japan, where he has established the first geriatric medical program in that city at the Kyoto-Katsuru Hospital, part of the Kyoto University Medical Schools. Others are leading other geriatric programs. So there is a tremendous market for these people and a tremendous need.

Senator PERCY. One last question to you. You have mentioned that there has been a development and interest shown by students and we are glad to hear that. You have also been instrumental in the development of geriatric programs in several medical facilities. How were you able to secure the budget and identify roots that you suggest as "musts" in your statement? What advice would you give to other interested medical professionals who would want to develop similar programs?

Dr. LIBOW. Well, to start with, I hope that support from Dr. Butler and the increasing involvement of the Administration on Aging will afford other universities and other centers the opportunity to do what we did and with less financial constraints. There is certainly a need for more financial support for this new field. But I am quite proud of using a different approach. What we did, Senator, was utilize some of the wasteful dollars spent on medical care in long-term institutions and convert these dollars into high-quality physician care and leadership, while simultaneously providing these physicians with geriatric medical residency training.

This approach has also been very cost effective. We pay $9,000 per year less to the resident physician than was paid to the unskilled "house doctor" who previously worked at our facility. Thus, we have enormously improved patient care while reducing salary costs by $50,000 to $75,000 per year. There is so much money available in the care of the elderly that what we really need to do is redirect our use of the money.

Senator PERCY. With the permission of our audience, we are going to adjourn promptly at 10 o'clock. We have secured permission to keep the room until 10:15—I trust without time and a half payment for an extra 15 minutes more, having followed the President's $1,000-a-plate dinner held in this room last night.

We really have only 20 minutes, and we have enough questions up here for 20 days. If any member would like to respond who found objection or would like to challenge something said by someone else, please do so as briefly as possible. If not, we will go right to the questions.

Dr. Butler, did you want to comment?

INADEQUATE PHYSICIAN TRAINING

Dr. BUTLER. Yes. Actually, I think, at the time I signified a desire to speak, Dr. Libow had not spoken, and I think he has expressed much of what I wanted to say. Maybe to repeat, if we know so little about aging, then we must create and maintain conditions that are favorable

to our building new knowledge and new information—and not the opposite—namely, to avoid it. If we do have some valuable information and knowledge which is not known to many people, and I am afraid it is not, then we must indeed teach it and apply it. I must say that one of my great disappointments insofar as the National Institute on Aging is concerned is that less than 4 percent of the grants have come from investigative medicine. That says quite a lot when you consider the enormity of the problems.

I would also like to say that unless the schools of medicine have created favorable catalytic atmospheres, then departments within those departments of medicine are not apt to address their attention to aging.

I am homemade, too, and I had not realized that. I did want to stress the fact that my own remarks come from clinical, as well as research, experience. When I talk about my colleagues, I don't do it lightly in saying that, indeed, there is a credible absence of knowledge. No one mentioned the older people themselves and I would like to point out that they have many, many complaints about the care they receive.

There is not only SAMA—the Student American Medical Association—but I had an occasion recently to spend an evening with a dean of a medical school, I will not name, who spoke proudly of how well trained his students were. The next morning I had occasion to meet with his students, senior medical students, who spontaneously spoke about how ill-prepared they were to work with older people, how little knowledge they had, how little education they had of epidemiology and pharmacology. I would like to remind you that 75 percent of practicing physicians have expressed the lack of proper training. There are diseases which are new, such as diseases which make a difference clinically with broad vulnerabilities.

I would just like to suggest that it would be very, very rewarding if our medical students had a greater exposure to different aging populations. If our medical students saw only children with irreversible conditions and there were no well-baby clinics, how many medical students would be interested in pediatrics? We have to give them a broad based exposure.

Finally, I would love to see, as one way of showing medical interest, our National Board of Medical Examiners include a couple of questions about the elderly for our medical students as one way to stimulate interest.

Now if you really want to answer the question without getting scientific, it would also be interesting to test the 300,000 practicing physicians in the United States and see if indeed they do know what we know exists in the corpus of knowledge about geriatric medicine.

Senator PERCY. Thank you very much.

Any other panelists?

If not, then, Mr. President, I turn the questioning over to you. As I look at this, I wonder how you are going to select, out of all those questions; I don't know.

Dr. BINSTOCK. All I can say, Senator, is that I am glad I am not standing for reelection for president of the Gerontology Society. [Laughter.] In selecting from this collection of audience questions, I have just probably made 5 friends and 300 enemies in the process.

However, I can say that what I have tried to do is select brief questions that reflect many thoughts expressed in many questions and to hit sharply several points that were not covered directly in the testimony or that bring issues to a head.

Are Specialties Necessary?

First, a question combining two questions which were directed to Drs. Berliner and/or Cooper. One person expressed it, "Why does the medical profession recognize a need for a specialty in pediatrics and not in geriatrics?"

The other person expressed it, "According to the logic of Dr. Berliner, does it not seem appropriate to discontinue the specialty of pediatrics?"

Dr. Berliner. In fact, it does. [Laughter.] There is one aspect of pediatrics which deals with the new born and the first 6 months to a year of life. There are problems which are unique in that age group. Beyond that I see no reason why pediatrics should be separate. Of course, my pediatric friends don't agree with that. In fact, I do not believe that there is very much logic in the separation of the remainder of pediatrics on internal medicine.

Dr. Binstock. Dr. Cooper, how do you feel about that? Should pediatrics as a specialty be abolished?

Dr. Berliner. I think he should be excused from answering this question; he will get into much trouble. [Laughter.]

Dr. Cooper. I would like to say, as I did in my written testimony, that the association has nothing to do with the designation of specialties. That comes from a liaison committee on specialties which has joint membership with the American Medical Association and the Board of Medical Specialties.

Senator Percy. We accept that disclaimer.

Now would you like to comment further?

Dr. Cooper. I think I would agree very much with what Dr. Berliner has said. As a matter of fact, I think that the development of family medicine is a move in the direction toward the fact that there is not this differentiation on an age basis. There are special problems, as I think there are in geriatrics, but I think those are minor in comparison with the communality of problems.

Dr. Binstock. Thank you, Dr. Cooper.

The next question is for Dr. Libow. Are there any cogent reasons why a specialty of geriatrics should not be instituted in the United States? I am looking for brief responses, you understand.

Dr. Libow. No. [Laughter.]

Dr. Binstock. A question for Senator Percy. Do you feel there might be some parallel between the resistance of organized medicine, represented by the American Medical Association's resistance to health insurance for the aged, and the resistance of organized medical education to the need for special attention to geriatric education?

Senator Percy. I don't notice any difference in the inertia about changing an existing status, and I have noticed in the Senate we have the same problems with the adaptation and change and acceptance of concepts. As a result of this kind of hearing, and as a result

of the wide dissemination of the views of our panelists, I would hope that we are going to move the immovable and make some progress; I think that we can.

Dr. BINSTOCK. Thank you, Senator.

TRAINING FOR GERIATRIC NURSES

Dr. Butler, is the National Institute of Aging concerned for educational programs for other health care professionals; namely, professional nurses?

There is a dearth of professional nurses prepared in gerontological nursing. It is true in nursing also that there is a lack of adequately prepared faculty in the field of gerontological nursing.

Who are the clients of the National Institute on Aging?

Dr. BUTLER. It should be clarified that the National Institute on Aging cannot train for purposes of service. We are only permitted by legislative authority and mandate to train for research. Certainly research nursing, research for medical social work, research for any of the variety of health professions and scientific professions is perfectly welcome. People can submit proposals toward that end. Unless the law changes, we cannot train.

Dr. BINSTOCK. Dr. Libow.

Dr. LIBOW. I think that is an important point. It would be important that either the mandate of the National Institute on Aging be changed or that within the Government one new agency be established to combine all the other agencies so that for service and training of professionals in this field of geriatrics, those of you in this audience and others in this field would know where to turn.

Dr. BINSTOCK. Thank you.

Now a question for Dr. Cooper. You have identified the lack of money as a key reason medical schools have not adequately responded to geriatric medicine. Is the problem, rather, one of priorities set by the medical schools relegating geriatric medicine to the lowest level?

USE OF MEDICARE FUNDS

Dr. COOPER. Many of the sources of support are not fungible. Dr. Libow has talked about the fact that he has State lines which he can use in residency training. The medicare law does not permit you to collect under part A for residents while they are in the outpatient department or in an ambulatory care setting. Unless an institution has the kinds of funds that the State apparently has provided Dr. Libow, you cannot just convert the support for residency training under medicare into ambulatory care, home care, nursing home care, and so on, because there simply is no part A for that aspect of medicare.

Dr. BINSTOCK. Dr. Libow, you seem to be ready to respond to that.

Dr. LIBOW. If interns and resident physicians work in the outpatient department and/or emergency room of an institution with an approved teaching program, then the cost of their services is reimbursed through part A of medicare. If it is not an approved teaching program, then the expense is covered under part B of medicare.

Dr. BINSTOCK. I think we have time for about two more questions. The next question is to Dr. Cooper. The tradition of the medical profession is to follow social prestige and the economics of income. The aged are not one of the elite groups in both respects. How do you propose to break this mismatch of medical needs of the elderly and the traditional focus of the medical profession on social prestige and the economics of income?

Dr. COOPER. Well, I am sure that the AMA would not feel that I had the authority to speak for the medical profession—they have pointed that out on several occasions.

I think that there is a mismatch between reimbursement in a variety of areas in care and the need for care. The association has recommended, as a matter of fact, that a reexamination be made of the methods of reimbursement for care so that care is reimbursed appropriately and that the larger amount of reimbursement that is given for procedures is more equated, with the two or more evenly equated. So as far as we are concerned, there is a mismatch, there is no question, and the whole reimbursement system in this country does favor the carrying out of procedures rather than delivery of care.

Dr. BINSTOCK. I gather the question is: How would you propose to break that cycle?

Dr. COOPER. We think it is to be broken by having medicare reexamine its reimbursement procedures.

Dr. BINSTOCK. Finally, a question for Senator Percy. Would you please comment on this?

AFFIRMATIVE ACTION IN MEDICAL SCHOOLS?

Discrimination on the basis of race, color, and national origin is proscribed behavior for medical schools receiving public dollars. Discrimination on the basis of age is more subtle, but nonetheless devastating. Perhaps the time has come to require, first, affirmative action on behalf of training physicians in aging and, second, imposition of disincentives, like loss of funds, for failure to have clear identifiable didactic and clinical training programs in geriatric medicine. Isn't the time for cajoling and pleading long past?

Senator PERCY. I hope not. I am really quite reluctant to go into a field—where you really want institutions and individuals to go into a field because they feel compelled to do so because of the need. I am not sure we have done the most effective job that we can of trying to sell the need for this. I would want to exhaust that first before we went into compulsion, which has all sorts of backlash aspects to it.

I think we have got a solid body of evidence if we could get this before the medical schools and if we could carry it to the AMA. I intend to start right in my own State with the State medical society, and I intend to work through our medical schools to do everything I can and to get other members of the committee to do it also. If we find we totally fail, then there is something wrong with us. I think we have enough of a story to tell—if we can get it across and then have the enthusiasm, rather than have it just one of the programs of the Federal Government, which comes in with a hammer and a carrot, or whatever it may be, and compels us to do it.

Now I feel inclined to try it that way before I go the other way. I just think rationality is much better than compulsion. In this case I think we can make a solid case for it. I think the enthusiasm of this group, as we go out, will help us with that job. That would be very much my preference.

Dr. BINSTOCK. Thank you. There is one last question here for me. "Can we have a copy of the testimony presented tonight before the society meeting ends this week?"

I am informed that the answer is "No." The hearing record will be kept open for 1 month. If you want the printed copy of the hearing, check the box on the blue sheet, fill in your address, and hand it to the staff or mail it to the committee in Washington as indicated on the blue sheet.

I also remind you that if you wish to have a statement submitted for the record, also mail it in on the blue sheet to the Senate Committee on Aging in Washington.

Senator Percy, I would like to thank you so much for holding this hearing with us this evening. It has been a great experience.

Senator PERCY. I would like to express appreciation on behalf of the very able staff who, I think, is one of the finest and the most educated staff we have in the Senate—Bill Oriol, John Guy Miller, Pat Oriol, Debbie Kilmer, Alison Case; and from the Select Committee on Nutrition and Human Needs, Wayne Fletcher; and Annabelle Short, our court reporter. I express deep appreciation to them but, I think, on behalf of them I can say that this never would have been possible without the initiative, the encouragement, and the fine cooperation of Dr. Binstock. It has been an honor to have been with you.

This is a brilliant panel, one of the finest in 10 years in the Senate that I have ever been privileged to meet with. We will benefit for a long time to come from what you have shared with us. We hope that all of you will go forward with a renewed feeling that you have appeared before a committee that has been able to get an awfully lot of things done, the U.S. Senate Committee on Aging, which I represent and feel to be the consensus of this particular group.

Thank you very much indeed for your participation.

[Whereupon, at 10:17 p.m., the hearing was adjourned.]

APPENDIXES

Appendix 1

STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. STATEMENT OF CARTER C. OSTERBIND, CHAIRMAN, PUBLIC POLICY COMMITTEE, ASSOCIATION FOR GERONTOLOGY IN HIGHER EDUCATION, WASHINGTON, D.C.

In response to Senator Percy's general invitation at the hearing, the board of directors of the Association for Gerontology in Higher Education (AGHE) has instructed the chairman of the public policy committee to submit this written testimony so that the views of AGHE may be a part of the hearing of the Senate Special Committee on Aging which was convened in New York October 13, 1976, re: "Medicine and Aging: An Assessment of Opportunities and Neglect."

It is appropriate first to very briefly state the purpose of the Association for Gerontology in Higher Education.

With growing public interest in aging during the past several years, many colleges and universities have instituted gerontological education and research programs. The number of programs continues to grow. A directory, prepared by AGHE under a grant from the Administration on Aging, lists 1,200 educational institutions with programs in gerontology. The Association for Gerontology in Higher Education was established to better represent these institutional programs nationally. The specific purposes of the AGHE are: (1) to unite in common organization educational institutions which conduct research, provide academic or professional training or other educational services in gerontology, and to provide a network of communication among such institutions; (2) to promote and encourage the education and training of individuals preparing for research or service careers in gerontology and to increase the awareness of the general public of the need for such education and training; (3) to provide a public forum for members to exchange ideas and knowledge which advance gerontology in higher education; (4) to provide an effective base for continuing cooperation with public officials, voluntary organizations, individual membership associations, and other groups interested in aging and education. The current membership of AGHE includes 4-year colleges, graduate universities and consortia, as well as other institutional affiliates with academic programs and interests in gerontology.

The members of AGHE have strongly endorsed the legislation creating the National Institute on Aging and the purposes for which it was created as set out by the Congress in Public Law 93-296. The president of AGHE, in his report to the membership in 1975, reaffirmed the support for NIA and voiced the strong hope that in addition to research support, the Congress would make additional funds available to NIA for training and for NIA staff support. At the annual meeting of the AGHE in Washington March 3, 1976, the program plan of AGHE called for effective liaison with NIA. A representative of NIA was invited to meet with the membership of AGHE so that views could be exchanged, and the support and interest of AGHE made clear. In appointments to the public policy committee, the president of AGHE designated a committee member as the liaison with NIA.

The stated mission of NIA as set out in the National Institutes of Health publication No. (NIH) 76-1129 was unanimously endorsed by the executive committee of AGHE at its meeting in New York on October 15, 1976. This mission is stated as follows:

"The National Institute on Aging was established for the conduct and support of biomedical, social, and behavioral research and training related to the aging process and diseases and other special problems and needs of the aged.

"The motivation of Congress in establishing the Institute was that: (1) The study of the aging process, the one biological condition common to all, has not received research support commensurate with its effects on the lives of every individual; (2) in addition to the physical infirmities resulting from advanced age, the economic, social, and psychological factors associated with aging operate to exclude millions of older Americans from the full life and the place in our society to which their years of service and experience entitle them; (3) recent research efforts point the way toward alleviation of the problems of old age by extending the healthy middle years of life; (4) there is no American institution that has undertaken comprehensive, systematic, and intensive studies of the biomedical and behavioral aspects of aging and the related training of necessary personnel; (5) the establishment of a National Institute on Aging within the National Institutes of Health would meet the need of such an institution."

The board of AGHE endorsed that statement and the following one, which appears later in the same publication:

"In order for society to keep elderly people independent and functioning members of society, we must know more about the relationship between social functions and health. Toward this goal, the Institute will conduct research in areas such as the effect of mandatory retirement, the problems of transportation to community and medical care facilities, and the stigma attached to old age."

Through training and research, AGHE has, as one of its central purposes, the focusing of educational resources on all aspects of aging and the aging process.

The testimony submitted by Dr. Robert Butler, the Director of NIA, very cogently states, in language that can be understood by all professionals in the medical, health-care, and related fields, as well as by all citizens, the importance of NIA's role—a role which is strongly supported by AGHE. In addition, AGHE is committed to the position that research in the field of aging, both basic and applied, should be fully coordinated with training and service and that the need for educational programs in aging should be clearly identified as having a high priority in the programs of post-secondary educational institutions in the United States.

Throughout the hearings it became increasingly clear that there is a strong need to deal with the mismatch between the funds committed to training students about the medical and health-care needs of older people and the large amount of health-care dollars that go to the care of older people. If health-care of older persons is to be effective in the United States, then unique medical and health-care needs of older people must be incorporated into the training programs for medical students.

Knowledge generated through our educational institutions has contributed to the increase in the average life span, and AGHE holds the view that these same educational institutions have the opportunity through research, training, and service to make this longer life meaningful to society and to each of us who is privileged to have a long life. AGHE members think it is of overriding importance that educational programs bring the full resources of educational institutions—all involved professions and disciplines—to bear on this educational challenge. It should be noted that the involved areas include the allied health fields—dentistry, podiatry, public health, etc., as well as the social and behavioral disciplines. It is the view of AGHE additionally that there is an important role to be played by educational institutions at all levels of training, and AGHE is specially concerned that the resources of post-secondary educational institutions embracing public and private community colleges, public and private degree-granting institutions, including universities and professional schools, be fully drawn upon in this effort.

The policy and program of AGHE accord with the educational needs that Senator Percy, the chairman of this hearing, and Dr. Butler, Dr. Leslie S. Libow, and Dr. Theodore Sherrod have so clearly stated. AGHE will work with each of its members to implement educational programs responsive to the medical and health-care needs that have been identified today in this hearing.

This very informative hearing, according leading medical educators the opportunity to present views before the Senate Special Committee on Aging and also affording the members of AGHE and the Gerontological Society with the oppor-

tunity to provide input on the very searching question of medicine and aging, is further evidence of the significant service of the U.S. Senate's Special Committee on Aging. The executive committee of AGHE voted to strongly urge the Members of the Senate to continue this useful committee when the Senate considers the question of committee reorganization.

ITEM 2. STATEMENT OF ERIC PFEIFFER, M.D.,[1] CHAIRMAN, CLINICAL MEDICINE SECTION, THE GERONTOLOGICAL SOCIETY

The Need for Curriculum and Faculty Development in Geriatric Medicine

These remarks are presented as an outgrowth of accelerating activity and mounting concern about mechanisms which will assure America's most experienced citizens the kind of health care which is specifically responsive to their needs and circumstances. While the advent of medicare and medicaid have already decreased the financial barriers, and while any of the proposed programs of national health insurance will undoubtedly move us further in that direction, the development of specially trained health manpower to meet the health needs of the elderly is in no way addressed by these programs. For this reason, the leadership of the clinical medicine section of the Gerontological Society of the American Geriatrics Society and the Council on Medical Education of the American Medical Association have been striving to focus on specific additional barriers to good health care for older Americans and to recommend administrative and legislative remedies for this problem. The specific issue which we have identified is the need for curriculum development and related faculty development in the field of geriatric medicine.

The central issue is this: The basic professional curricula of the core professions providing medical care to aging patients (family medicine, internal medicine, psychiatry, and nursing) contain little or nothing specific to working effectively with the specialized aspects of care of the aging. In view of the growing number of elderly persons in this country (this is the fastest growing segment of our population) and in view of the greatly increased requirement for medical services on the part of older patients (in dollar terms, three times as much as for persons under age 65), this present situation must be changed on a high priority basis.

How can this change be accomplished?

There are many possible responses to this question, several of which are being pursued by individual professionals working in the field of aging and by organizations like the Gerontological Society, working alone or in concert with other associations such as the American Geriatrics Association, the American Medical Association, medical specialty groups, medical specialty boards, the media, and consumer groups. These efforts include giving greater visibility to the field of aging; continuing education efforts and/or requirements; the inclusion of gerontological content in general or in specialty qualifying examinations; media and consumer pressure for more readily available specialized professional and paraprofessional personnel to serve the medical needs of the aging.

But these efforts alone are not enough, and their effects will not be felt soon enough. For this reason, a new legislative initiative is recommended to redress a critical situation.

It is recommended that the Congress enact legislation for a new program to stimulate curriculum and faculty development in the field of geriatric medicine.

Specifically, it is recommended that funds be appropriated for the development of faculty trained and experienced in geriatric medicine to serve as educators to future health care providers. At a minimum, the creation of 40 new faculty positions, 10 each in the field of internal medicine, family medicine, psychiatry, and nursing, is recommended. Funding for such new provision shall be awarded on a competitive basis, with awards being made to those institutions who have, through the utilization of their own resources, already demonstrated the capability and commitment to the teaching of geriatric medicine. The anticipated

---

[1] Dr. Pfeiffer is associate director for programs, Center for the Study of Aging and Human Development, Duke University, Durham, N.C., and currently on sabbatical leave from Duke University as acting director of the Davis Institute for the Care and Study of the Aging, Denver, Colo.

cost of such a program is estimated to be approximately $2 million per year. Funding for a period of at least 5 years is recommended.

The anticipated benefits of the recommended program are: (1) reduction in the number of visits by the elderly to physicians who lack expertise and skill in diagnosis and treatment of diseases of the elderly; (2) decreases in the length of hospital stay through more efficient management of acute and chronic illnesses of the elderly; (3) decreases in the likelihood of medical complications through early detection of disease, using comprehensive assessment procedures prior to the onset of complications; and finally (4) a major upgrading of the quality of medical care delivered in long-term care institutions.

Mr. Chairman, I know that the Senate Special Committee on Aging has long been working toward these last several goals. Prompt implementation of this recommendation can move us a long way toward their accomplishment.

ITEM 3. STATEMENT OF WILLIAM E. ARNOLD, MULTIDISCIPLINARY COMMITTEE ON AGING, ARIZONA STATE UNIVERSITY, TEMPE, ARIZ.

The Value of the Old

To assess the needs in the area of aging and medicine, several key research projects need to be undertaken. We need to understand the role of the aged in American society. An examination of the research to date suggests that the issue of attitudes toward the aged and knowledge about the aged needs further clarification. Kilty and Feld (1976) brought this point home when they examined the attitude scale toward older people. Research needs to be done to determine the effect of factual information on beliefs and opinions. It would also be useful to know on the basis of demographic information which groups have more knowledge about age and the aging process. As a corollary, it would be desirable to find out what knowledge older persons in our society have about the aging process.

Once we can make a distinction between information and knowledge on resulting attitudes, we should also make a distinction between the old as a generic group and individuals within the group. Since most attitude scales discuss older people as a classification, we know very little about how individuals feel about specific older people that they might know. We tend to discuss generalized attitudes rather than personalized attitudes. Therefore we need research to determine the differences and similarities in our views toward generic groups as well as individuals within that group. For example in a pilot study, students consistently rated their grandparents higher on a credibility scale than they did old persons in general.

Finally, we need better ways to describe our attitudes toward the old. As indicated by Arnold (1976), we have tended to view the image of the old by asking such questions as whether or not old people are generally stuck in their homes and that they are only interested in putting in their hours. On a positive side, we ask such questions as "Do old people love life and do they grow wiser with the coming of age?" This may tell us something of the social-psychological attitude toward the old but it does not truly reflect credibility as defined in the communication literature. Thus, we need to consider the image of the old from a multidimensional standpoint viewing them on the dimensions of character, competence, dynamism, and sociability. In doing so we would have a better understanding of what images we hold for either the generalized old or the old individual.

With the need with the new knowledge of attitude and credibility, it would be useful to replicate the study conducted by the National Council on Aging in 1975. We need to explore the differences between the young and old including social economic background, rural-urban, and education. It would even be useful to explore this on an international level.

Research needs to be undertaken on the relative contribution of several societal factors on the old. If the mandatory retirement law is truly one of the major causes of the conditions for the elderly, then further research needs to be instituted which would give us a better perspective on the relative contribution of retirement. Does retirement, for example, force the suicide rate up for the older population? What contribution does industrialization or urbanization in a youth-oriented society play in creating an image for the old?

One of the major needs in aging research is for a greater exploration of behavior rather than the traditional analysis of beliefs and attitudes. For example, the National Council on Aging (1975) studies suggested rather negative attitudes toward the aged. Does this manifest itself in our treatment of the old? The presentation by a retirement home architect at the 1975 conference on human values and aging suggested that behavior did follow attitudes toward the old. If the old were viewed as unable to manipulate corridors without simplistic presentation of colors, then the retirement home was designed accordingly. We know very little about the behavioral manifestation of attitudes. It would be useful to explore historically the treatment of the old with expressions of attitudes and beliefs on the elderly at that time.

CONCLUSIONS

Far more research needs to be conducted on our attitudes and behaviors toward the aged in our society. If we are to understand the needs and areas of neglect with regard to medical care for the aged, we need to do some of the basic research which precedes the medical area.

One is left after listening to the statements about the aged that the old are simply a group of guinea pigs on which we can try all kinds of techniques and apply all kinds of research skills. On the contrary, it is hoped that the research done with and about the old will have societal value and that conditions may be improved for the elderly in America. If we have created a condition in which the old are viewed as ugly and undesirable, it is only through research that we can find the reasons and the means to change this condition.

ITEM 4. STATEMENT OF SAUL KENT, EDITOR, *AGING TOMORROW*, NEW YORK, N.Y.

Several witnesses have testified to the need for a separate department of geriatric medicine in our medical schools. They have argued that the elderly have specific medical problems requiring special attention. Other witnesses have testified that there is no need to single out the treatment of the elderly in our medical schools because aging is a developmental phenomenon and there are no diseases that strike the elderly alone.

Both these arguments are essentially correct, but the contrasting proposals for which they are given are equally inadequate to meet the health care needs of older adults. In my opinion, these needs can best be met by shifting our attention from the treatment of specific diseases to treatment of the normal aging processes that underlie the onset and expression of degenerative disease and the general loss of strength, vigor, and well-being that occurs in all of us with advancing age. While it is true that the elderly have specialized medical needs, these needs are direct consequences of lifetime patterns of normal aging exacerbated by poor health habits, exposure to environmental pollutants, and excessive stress.

I therefore propose the creation of a department of clinical gerontology in all medical schools which would encompass all age groups but would deal exclusively with the deleterious effects of aging and such age-dependent diseases as heart disease, stroke, maturity-onset diabetes, most forms of cancer, arthritis, and organic brain syndromes.

This department would focus entirely on preventive health care in childhood and young adulthood, with special emphasis on the development of therapies to delay the onset of senescence. In treating older adults the department would continue its commitment to preventive health care, but would also pursue therapies to reverse aging processes and rejuvenate the aged.

An important division in the department of clinical gerontology would be devoted to basic biological research aimed at developing anti-aging therapies. Another division would concentrate on measuring the rate of aging in human subjects to facilitate the testing and evaluation of anti-aging therapies.

Such a department would be well equipped to do battle with the true adversary of all older adults—the time-dependent decline in physiologic function that we call aging and the degenerative diseases engendered by this process.

ITEM 5. STATEMENT OF NONA BOREN, M.S.W., MICHAEL McCALLY, M.D., AND L. THOMPSON, M.D.,[1] OF THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE AND HEALTH SCIENCES, WASHINGTON, D.C.

The Need for Curriculum Development and Geriatric Care Activities in Gerontology in Schools of Medicine

These remarks are presented to underscore this institution's recognition of the need for medical schools to address the needs of the elderly. They are also intended to inform you and your committee about a major new program at this institution made possible by a grant from the Administration on Aging, designed to impact the training programs of medical, nurse practitioner, physician's assistant, social work and allied health students, and to provide for faculty development activities.

The new program at the George Washington University grew out of a concern and awareness on the part of this institution regarding the neglect of the elderly, the scope of the problem, the implications of neglect, and the need for medical institutions to take a lead in correcting the neglect.

The health and mental health problems of the aged in our society continue to be neglected not because of ignorance, but in spite of the increase in knowledge about the aging process and major advances by the medical profession that offer prolonged life.

The nature, extent, and reasons for this neglect can no longer be dismissed by citing failures in policies at the national level. The neglect is reflected in the goals and priorities of the institutions, including medical schools, that are responsible for training our health professionals and in the attitudes held by persons responsible for teaching and for the delivery of care to the elderly.

The problem is grave and pervasive. While there have always been people who lived to a great age, there are more people living into old age than ever before and this trend is likely to increase. Since 1900, the over 65 population in the United States has grown much faster than the rest of the population. At that time this age group numbered approximately 3 million. By 1940 it had nearly tripled to approximately 9 million and again by 1970 had more than doubled to 20 million. If the present trend continues, it is estimated that by the year 2000 there will be 31 million persons over 65 in the United States. During the present decade, 1970 to 1980, the older population is expected to grow by approximately 23 percent compared with an expected 8 to 9 percent increase for the total population.

The implications of neglect for health care delivery are very real. Older persons experience more acute and chronic disease than the younger population; psycho-pathology in general, and depression in particular, increase with age; suicide sharply increases with age in elderly white males; and while a little more than 10 percent of the population is over 65, they use 27 percent of the health dollar. Yet little attention is given to the promotion of health and the improvement of the quality of life for the elderly—efforts that would work to alleviate the complications of chronic disease and depression that frequently results from inevitable losses and isolation.

Much of the neglect in provision of adequate training or health care delivery is the result of attitudes on the part of practitioners based on myths about aging and their own fear of the aging process and of dying. The neglect and stereotype attitudes toward aging and failures in delivery of adequate health services to the aging are reflected in and reinforced by educational institutions responsible for the training and education of professional personnel who could play a part in redressing the neglect and discrimination. In professional training programs for the helping professions (medicine, allied health, social work, nursing), generally little attention has been given in the formal curriculum or in field experiences to the aging process and to problems of the elderly. The human development sequence in the most professional schools typically begins at birth and ends at young adulthood. The situation is no different in medical schools. Here again the human development instruction typically neglects the period of life relating to middle age and aging. Course offering with a specific focus on problems of

[1] The George Washington University School of Medicine and Health Sciences. Dr. Bowles is the dean for academic affairs, Dr. McCally is associate dean and principal investigator, the Gerontology Program, and Ms. Boren is the director, the Gerontology Program.

the elderly are rare. An example of this neglect on the part of medical institutions is derived from a survey of the Association of American Medical Colleges Curriculum Director which reveals a large disparity in electives given for credit among the 15 different categorical areas listed. During the 1972, 1973, and 1974 academic years, not one of 119 medical schools reported electives which focused on problems of the elderly. Even by 1975, only 32 schools or 27 percent offered such electives. This can be compared to the categorical areas of drug abuse and human sexuality where electives were offered in over 60 percent of the schools for all the years (1972 through 1975). In addition, the literature demonstrates that few medical schools and teaching hospitals provide adequately for clinical experiences in geriatrics for undergraduate students or for post-graduate training in geriatric care.

The failure of medical institutions to provide adequate curriculum content and field experiences in the area of gerontology and geriatric care is compounded by the fragmentation of education experiences for a variety of health professions who must work together, but seldom learn together. Few medical schools are so organized as to offer opportunities for inter-professional training and collaboration. Equally neglected is multidisciplinary approach to teaching about health care for the elderly, their problems and society's responsibilities in addressing these problems. The result is that not only are health practitioners poorly informed about the health care needs of the elderly, but equally uninformed about the competencies and roles of other professionals in providing services and influencing policies that impact on needs of the elderly.

The George Washington University School of Medicine and Health Sciences has received a grant for the fiscal year 1976–77 from the Administration on Aging to introduce and improve gerontology and geriatric care content in educational programs within the George Washington University School of Medicine and Health Sciences. The program is based on a commitment to a multidisciplinary effort on the part of several major departments within the school of medicine and health sciences and other schools and departments in the University.

We anticipate that such multidisciplinary collaboration will have a number of desired outcomes: (1) Multidisciplinary curriculum development activities will influence the curriculum of the school of medicine and health sciences affecting undergraduate students as well as post-graduate physicians; i.e., residency training programs. These activities will also impact on undergraduate programs in sociology, recreation therapy, and on graduate level programs in sociology, recreation therapy, health care administration, and social work; (2) Multidisciplinary collaboration will provide a unique opportunity for health and health-related professionals to work and learn together. In doing so, it is anticipated that they will discover new potentials for professional growth in the field of gerontology and develop instructional expertise in activities focusing on faculty development such as multidisciplinary faculty seminars. This will, we hope, promote this institution's development of a permanent program with financial commitment to gerontology and the field of aging.

In summary, the George Washington School of Medicine and Health Sciences is moving to actively address the problems of training for better health care for the elderly. Our goals are to provide for all our students structured opportunities to examine attitudes toward aging and older persons, knowledge and information about health-related aspects of aging, and clinical skills appropriate to the management of the illnesses of older individuals. Our model for such a program is one of interprofessional education. Our capability resides in the fact that George Washington University has only a school of health sciences and programs for students of medicine, allied health fields, physician's assistants, and post-graduate physicians, which takes place in one facility with one faculty. Age-ism and gerontology is properly taught in schools of medicine and of health sciences.

ITEM 6. STATEMENT OF THE UNIVERSITY OF CINCINNATI GERONTOLOGY COUNCIL, CINCINNATI, OHIO

Gerontology at the University of Cincinnati

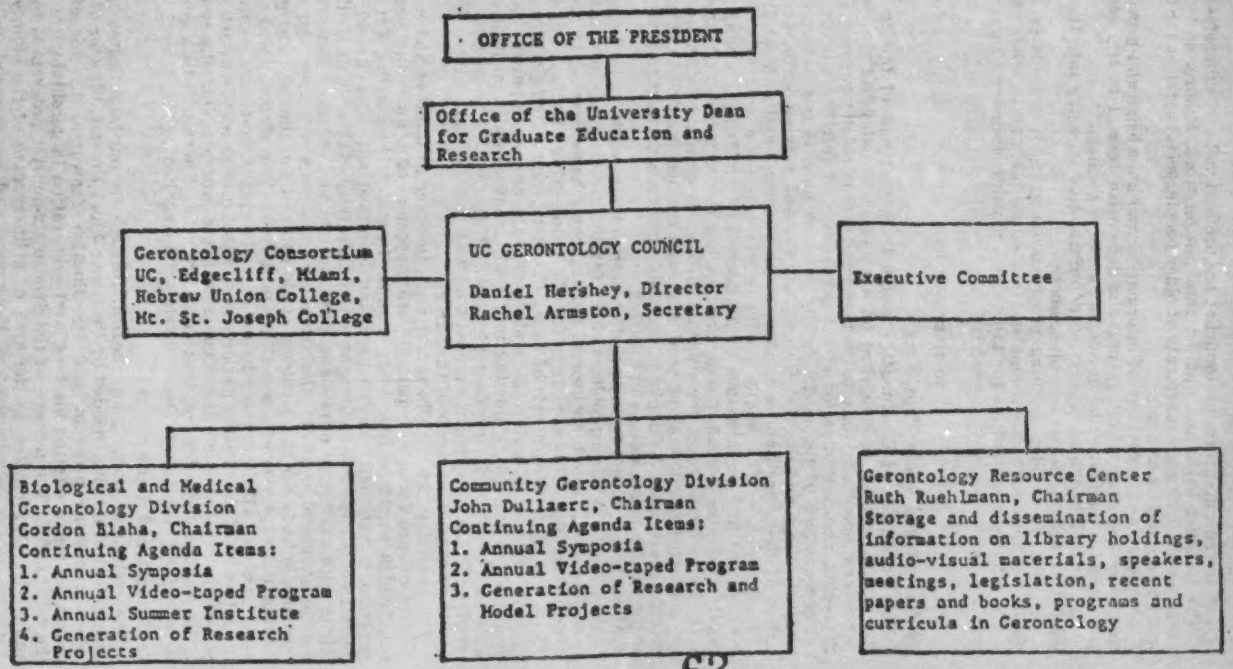
Gerontology is the discipline and practice that deals with the aging process and the special problems of aging persons. It is related to sociology, psychology, physiology, family practice medicine, nursing, community services, and even

business administration and engineering. The University of Cincinnati, through its gerontology council and associated groups, is committed to programs in gerontology which will lead to a better understanding of the developmental changes which occur as we grow old and how we might enjoy a long life with good health. Recent demographic data show that the 10 to 24 and 24 to 35 years of age groups are diminishing in proportion to the older population. Thus, we need to prepare for the future, as the elderly become numerous and insist on their right to a decent old age.

The establishment of a University of Cincinnati Gerontology Council in 1973, composed of recognized scholars whose teaching and research were related to gerontology marshalled the university activities in this field and focused them so that distinct areas of excellence could develop. There is much good work to be done, only requiring people and institutions to commit themselves. The University of Cincinnati has committed itself. In 1975, a gerontology interest group was formed, to function as the public forum for the dissemination of information on aging. Membership in this interest group spanned the full range, from the lay public to professionals working full-time in agencies providing services for the elderly. In 1976, the gerontology interest group was merged with the gerontology council in order to more closely coordinate our academic and public functions. In 1976, the gerontology resource center was organized, which serves as a clearinghouse for gerontological information. The staff of the gerontology resource center advises senior centers, agencies, and others on speakers, films, books, college programs and curricula, job opportunities and legislation pertaining to aging and the care of the elderly.

On the following pages we present the organizational structure of the U.C. Gerontology Council, our objectives, and a narrative describing the essence of our present and future activities: the teaching, research and public service functions of the U.C. Gerontology Council. We hope to contribute on many levels, from the pragmatic, community-based efforts at analyzing the services available for the aged to the intellectual, more esoteric attempt to understand the cellular changes which we call the aging process. We'll help employees find more satisfaction on the job and provide guidance for those in the vicinity of retirement. Perhaps we'll discover universal parameters which measure the age of persons, corporations, universities, and countries. And if we understand all these things, will we be able to assist in providing the blessing of long life in good health? We hope so.

ORGANIZATIONAL STRUCTURE OF THE UNIVERSITY OF CINCINNATI GERONTOLOGY COUNCIL


OFFICE OF THE PRESIDENT
Office of the University Dean for Graduate Education and Research
Gerontology Consortium UC, Edgecliff, Miami, Hebrew Union College, Mt. St. Joseph College
UC GERONTOLOGY COUNCIL
Daniel Hershey, Director
Rachel Armston, Secretary
Executive Committee
Biological and Medical Gerontology Division
Gordon Blaha, Chairman
Continuing Agenda Items:
1. Annual Symposia
2. Annual Video-taped Program
3. Annual Summer Institute
4. Generation of Research Projects
Community Gerontology Division
John Dullaert, Chairman
Continuing Agenda Items:
1. Annual Symposia
2. Annual Video-taped Program
3. Generation of Research and Model Projects
Gerontology Resource Center
Ruth Ruehlmann, Chairman
Storage and dissemination of information on library holdings, audio-visual materials, speakers, meetings, legislation, recent papers and books, programs and curricula in Gerontology

OBJECTIVES OF THE UC GERONTOLOGY COUNCIL

(a) Recruit and train personnel at the professional and subprofessional levels.
(b) Conduct basic and applied research on work, leisure, and education of older people, living arrangements of older people, social services for older people, and the economics of aging.
(c) Serve as a repository of information and knowledge and provide consultation to people and voluntary organizations with respect to the needs of older people and in planning and developing services to them.
(d) Stimulate the incorporation of information on aging into the teaching of biological, behavioral, and social sciences.
(e) Help to develop training programs on aging in schools of social work, public health, health care administration, education, and in other units.
(f) Create opportunities for innovative, multidisciplinary efforts in teaching, research and demonstration projects.

TO MEET OUR OBJECTIVES

To Recruit and Train Physicians

The University of Cincinnati, through its department of family medicine in the medical center, is embarked on a program of enlarging the experience of physicians, sensitizing them to the needs and care of elderly patients. Dr. Kenneth Frederick, associate director of the department of family medicine, responsible for the conduct of the model family practice unit, is the liaison between the medical college and the U.C. Gerontology Council, serving on the executive committee of the council and a member of its biological and medical division.

The department of family medicine has two main activities. First is the development and maintenance of an accredited residency training program in family medicine. Second, the department has the responsibility for establishing a family medicine track for students in the college of medicine. Both activities are dedicated to the task of producing well trained family physicians who can provide continuous, humanistic, accessible comprehensive care for all members of the family in an ambulatory setting.

Along with a model family practice unit to train residents in the management of the common medical problems of the family, the residency program has access to a voluntary, church sponsored, philanthropic home devoted to the long-term care of the aged. This facility is for 850 people whose average age is 84 years. The home offers three levels of care: (1) Independent living with medical care provided on a need basis; (2) a sheltered care area with partial daily medical supervision; and (3) a nursing unit with complete daily medical supervision. This provides for the resident physicians the opportunity to deal with aging people and their families in a micropopulation that is representative of the entire spectrum of long-term care of the aging.

For physicians in the Cincinnati area, in order to improve and maintain the quality of care for elderly patients, we propose to offer an annual summer institute, which would be four 1-day sessions in geriatric medicine. For each 1-day program, a nationally known physician identified with the clinical practice of geriatric medicine will be brought to the University of Cincinnati Medical Center. Along with university physicians, physiologists, and others, a coherent program will be arranged, whereby the attending physicians will hear and discuss the physiologic basis for the problems of old age and the clinical consequences (reflecting the expertise of the visiting physician). The second, third, and fourth 1-day sessions will be arranged similarly, differing in emphasis, as expressed by the interests of the visiting physicians. ConMed credits will be awarded for those physicians who complete the summer institute program. Our aim is to increase skills, change attitudes and provide information. There will be a comparing of notes and an updating of basic physiology as applied to the clinical physicians.

To Recruit and Train Nurses

The college of nursing and health, through its master's degree program in gerontological nursing, headed by Professor Janet Froome, director of the gerontological nursing program, and Dr. Rosalee Yeaworth, director of graduate programs, began offering masters level preparation in gerontological nursing in the fall of 1973. The purpose of the five- to six-quarter program is to prepare a nurse who can function in the area of primary care of the elderly. There is emphasis on the development of biophysical and psychosocial skills and the

knowledge needed to care for other persons in acute settings as well as in health maintenance, ambulatory care settings.

To Conduct Basic and Applied Research

The changes that occur in the various tissues and organs of the female reproductive system furnish a model of aging which may be applicable to other systems of the body as well. Measurement of circulating levels of hormones and uptake of these hormones is an important aspect of this study. Changes in the responsiveness of the tissues (ovaries, uterus) may occur even though their basic hormones are present.

Individuals who have worn an immobilizing cast or have been bedridden for extensive periods of time suffer a loss of motion when they again become ambulatory. Research is underway to determine whether or not heat applied to a casted joint during the period of immobilization will prevent the tissue changes characteristic of joint construction.

The heat given off by the human adult is measured directly in a whole-body calorimeter of simple but unique design. Measurements of the basal metabolic rate (BMR) are currently being made on elderly subjects every 3 months. To be tested is the hypothesis that there exists a critical level of BMR, below which the body does not possess sufficient vitality and senescent death may occur.

Long-term investigation of the immune function in nonhospitalized volunteers 80 years of age or older is proceeding. Some results of these studies suggest a subtle abnormality of T-cell regulatory function. It is anticipated that these clinical and laboratory studies will enhance understanding of allergic reactions and diseases beyond the age of 50.

The lifespan of systems such as single cells, multicellular organisms (the human body), corporations, and civilizations are being studied to elicit the factors affecting lifespan, the parameters which measure it, and definitions of birth and death. From this may develop a more meaningful measure of age, expressed not in years, but by some other intrinsic property.

Workshops are planned to sensitize grade and high school educators in relation to: stereotypes of the aged, the care and problems of aging persons, and attitudes of the young toward the elderly population.

The problems of adult children with respect to their elderly parents are being studied. The first stage would entail a series of in-depth interviews with a representative sample of adult children concerning the relationships they have with their elderly parents. The second stage would consist of workshops for the adult children in which information focusing on these problems would be stressed. In the third stage, a follow-up would be undertaken to determine if the workshop aided the relationship, and hence improve the quality of life for the elderly and their grown children.

We have organized two physiology of aging symposia in the last 2 years and the third annual physiology of aging symposium is being planned. Another program, normal aspects of aging, was presented in 1976.

To Service as a Repository of Information and Provide Consultation

We have recently formed a gerontology resource center under the aegis of the U.C. Gerontology Council. This center collects information on gerontology meetings and workshops around the State as well as films, video tapes, pending and passed legislation on the local, State, and national levels, dealing with aging and the care of the aged.

In cooperation with the Greater Cincinnati Gerontology Consortium of Colleges and Universities and the Cincinnati Council on Aging, the gerontology resource center provides advice and information to senior centers, agencies, and others in the community interested in gerontology. The center publishes a newsletter, maintains a composite mailing list, catalogs the gerontology library holdings in the Cincinnati area, and provides information on college programs and curricula in gerontology.

To Stimulate the Teaching of Gerontology

We teach the following courses at the University of Cincinnati in the area of gerontology: Aging Theories in Gerontology; Consumer Economics; Geriatric Nursing; Gross Anatomy; Investment Policy; Microscopic Anatomy; Old Age and the Community; Organic Medicinal Chemistry; Psychology of the Aged; Psychology of Death and Dying; Psychosocial Aspects of Aging; Social and Economic Security; Social Gerontology; and Stock Markets and Investments.

Because of our research and workshops, and with an active lobbying campaign by U.C. Gerontology Council members, we are helping to introduce basic information on aging into our curricula. We are members of the Ohio Network of Educational Consultants in Gerontology as well as the Greater Cincinnati Gerontology Consortium and the Association for Gerontology in Higher Education. We know what to teach: what remains is to convince others that their curricula are incomplete without gerontological content.

To Develop Training Programs on Aging

Our department of family medicine and the geriatric nursing program have training components. In addition, the University of Cincinnati's program in community health planning/administration offers graduate and undergraduate programs to help prepare those interested in careers in community health planning, organization, and administration.

To Create Innovative, Multidisciplinary Efforts

The U.C. Gerontology Council has undertaken cooperative curriculum arrangements whereby students at the University of Cincinnati may take courses free of charge at the other schools which, with the University of Cincinnati, make the Greater Cincinnati Gerontology Consortium. Thus, we share the best of the consortium schools. Through the consortium, we are investigating the possibilities of team teaching a basic sequence of courses in gerontology.

Appendix 2

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER AND QUESTIONNAIRE SENT TO DEANS OF MEDICAL SCHOOLS IN THE UNITED STATES BY SENATOR CHARLES H. PERCY

DEAR DEAN: As you may know, I have a strong and continuing interest related to problems of the elderly. I have served on the Senate Committee on Aging for several years; currently I am the ranking minority member of the Subcommittee on Long-Term Care. Our plans call for me to chair a hearing of this subcommittee in conjunction with the annual meeting of the Gerontological Society to be held in New York City during the week of October 14.

Our hearing will examine the emphasis placed on geriatrics in schools of medicine and the consequences in terms of physician's sensitivity to the special problems of the elderly.

In this connection, I would appreciate your taking a few moments to answer the following questions:

(1) Do you have geriatrics as a specialty in your curriculum?

(2) Do you have programs in which students, interns, or residents can serve nursing homes?

(3) Do you have programs which help serve the elderly in any other way?

I would appreciate having your response to each of the above questions by September 30.

With best wishes,

Sincerely,

CHARLES H. PERCY.

RESULTS OF QUESTIONNAIRE SENT TO 114 MEDICAL SCHOOLS BY HON. CHARLES H. PERCY

(1) Number of questionnaires returned—84. Percent return—74.

(2) "Do you have geriatrics as a specialty in your curriculum?"

Number answering "Yes"—3. Number answering "No"—81. Percent answering "Yes"—3.6.

(3) "Do you have a program whereby students, interns, or residents can fulfill requirements by serving in nursing homes?"

Number answering "Yes"—37. Number answering "No"—47. Percent answering "Yes"—40.4.

(4) "Does your medical school serve the elderly or those in nursing homes in any other way?"

Number answering "Yes"—47. Number answering "No"—37. Percent answering "Yes"—56.

Of the ways medical schools served the elderly or nursing home patients included: treating the elderly in university, county, or municipal hospitals (mentioned by 15 schools); operating outpatient clinics (mentioned by 8 schools); and research noted by 7 schools. Five schools boasted offering electives in gerontology (the research side of aging) and three noted offering electives in geriatrics (the clinical aspects of treating the elderly).

ITEM 2. LETTER FROM EARL C. COOKE, HOUSTON, TEX.; TO SENATOR CHARLES H. PERCY, DATED OCTOBER 29, 1976

DEAR SENATOR PERCY: I would like to express my sympathetic support for your efforts in the current hearing on "Medicine and Aging." In my work I have had much contact with medical schools and nursing homes and have seen many of the problems which you are concerned about.

I strongly share your feelings that geriatrics should be taught in the curriculum of medical schools and that this should involve service to nursing homes.

Much success to you in your efforts to get medical students further enlightened and interested in the care of geriatrics.

When available, I shall greatly appreciate your being so kind as to send me a copy of the hearing.

Very sincerely,

EARL C. COOKE.

ITEM 3. LETTER FROM TERRENCE T. KUSKE, M.D., ASSOCIATE DEAN FOR CURRICULUM, MEDICAL COLLEGE OF GEORGIA, AUGUSTA, GA.; TO SENATOR CHARLES H. PERCY, DATED SEPTEMBER 24, 1976

DEAR SENATOR PERCY: In response to your questions regarding programs for the elderly at the Medical College of Georgia, we do not currently have geriatrics as a separate subspecialty in our curriculum. Our curriculum is divided on more classic lines in which geriatrics would be covered predominantly within the specialty of internal medicine.

In response to your second question, we do have programs in which residents can serve nursing homes, specifically our own large nursing home facility. We have a very large immediately attached nursing home facility, the Georgia War Veterans Home, and medical care is provided by the university health clinics as well as night-call coverage being provided by our resident staff. In addition, a portion of the Veterans Administration Hospital is concerned with long-term care for many aged patients, and this is similarly staffed by our own residents.

As regards other programs which serve the elderly, assessment of the nutritional training programs of the elderly has been conducted on a regular basis as part of the nutrition electives for clinical students as well as the nutrition elective components of the students in the basic sciences.

I hope that this provides information that will be of use to you.

Sincerely yours,

TERRENCE T. KUSKE.

ITEM 4. LETTER FROM BERNARD E. NASH, PRESIDENT, INTERNATIONAL FEDERATION ON AGING, WASHINGTON, D.C.; TO SENATOR CHARLES H. PERCY, DATED OCTOBER 22, 1976

DEAR SENATOR PERCY: With reference to the very stimulating hearing you held on medical care for the elderly during the annual meeting of the Gerontological Society in New York, September 13–17, 1976, I would like to offer some observations about how geriatric care is organized in other countries, in the thought that these insights may be useful in our own case.

As you will recall, the hearing centered on the extent of the need for geriatric medicine in the United States. I was particularly struck, however, by the fact that after the hearing some members of this highly professional audience seemed confused about what geriatric medicine could encompass. Several people thought that geriatric medicine would end up being a specialty much like pediatrics whereby an individual would see a specialist solely based on the criterion of age. Not surprisingly, this alternative did not seem very appealing for fear that it would further perpetuate the segregation of the elderly from society.

In fact, a geriatric specialty operating much like pediatrics is just one alternative to organizing better care for the aging. It is an extreme alternative that, as far as I know, exists nowhere in the world. The existence of this confusion among members of the audience makes me fear that the whole concept of geriatric care may become politically unfeasible because of a widespread misunderstanding as to what it can represent. If professional gerontologists are confused about this issue, what will be the reaction of the general public whose support is necessary to any measures for improving medical care for the elderly?

The confusion arose in my estimation from the fact that no clear distinction was made by the speakers about the various levels of geriatric care that can be introduced. For example, at a minimum one can introduce courses in medical schools on physiological, psychological, and sociological aspects of aging; these

could either be mandatory or elective. At the next level, one could establish geriatric consultantships. Geriatric consultants would be called in by a general practitioner when the latter is puzzled by an older person's symptoms or when an older patient shows a complex interaction of symptoms. Such consultants could also oversee the teaching of geriatric medicine in medical schools. This is very much the model now in existence in the United Kingdom. (It should be noted that in the United Kingdom no more than about 20 percent of the elderly ever see a geriatrician; the remainder are treated by the general practitioner. In part, this may be due to a shortage of geriatric consultants but, in large measure, this is due to the fact that many older persons' ailments are quite similar to those of younger age groups, and no need to call in a geriatric consultant manifests itself.)

At a third and extreme level, one could create the specialty of a geriatrician who would serve much as a pediatrician does and automatically see all individuals over a certain age bracket. As stated before, as far as we know, such a practice does not exist in any country in the world. In short, we are setting up a strawman in focusing our thinking and debate around this issue and ignoring the merits of less radical alternatives.

For an excellent discussion of how geriatric care is organized in countries other than the United States, I recommend "Geriatric Care in Advanced Societies," edited by John C. Brocklehurst, one of England's foremost geriatric consultants. I would like to close with a quotation from Brocklehurst's book. According to him, geriatric care is desirable because, for older people:

". . . progressive care through departments (or facilities) providing acute, intermediate (rehabilitation), and then either long-stay or domiciliary care is likely to be needed most commonly. To achieve a smooth passage through these various stages implies a unified or coordinated administration and is perhaps one of the best arguments for a specialist service of geriatric medicine which can assume responsibility for the ill old person at an early stage and steer him through all the subsequent stages until his resettlement in the community, or in the most appropriate type of long-term care. By this means a uniformity of approach and a continued flow of information about the patient should have the best chance of happening. . . .

"The overwhelming arguments in favour of a specialist service would seem to be (a) the size of the problem, (b) the neglect it suffers where there is no such service, (c) the many clinical and organizational improvements that have occurred where a service has been established, and (d) the fact that those who engage in it find the work exciting, stimulating, and worthwhile."

With best wishes,

BERNARD E. NASH.

ITEM 5. LETTER FROM R. WILLIAM BURMEISTER, M.D., MEDICAL DIRECTOR, MOUNT ST. ROSE HOSPITAL, ST. LOUIS, MO.; TO SENATOR CHARLES H. PERCY, DATED NOVEMBER 17, 1976

DEAR SENATOR PERCY: Pursuant to your request at the recent Gerontological Society meeting for information concerning geriatric care programs and potential training approaches in this field, I wish to submit:

—A brief introduction to a program of geriatric hospital care demonstrating cost-efficient rehabilitative care of the elderly.

—Some background of the proposed expansion of these services into a day-hospital system of delivery.

—Identification of the possible role such an already-developed model could play in the teaching and demonstration of geriatric clinical medicine in a university-related program provided adequate teaching support is available.

The responses of the 150 participants from five Midwestern States attending a recently completed seminar (brochure enclosed),[1] along with the knowledge of the present deliberations of the Senate Committee on Aging and the National Institute on Aging, have served to reinforce my desire to respond to your request. The following then represents brief explanatory material concerning the points above. I should be most happy to supply additional material as deemed appropriate.

[1] Retained in committee files.

(1) Mount St. Rose Hospital in St. Louis, Mo., has developed, over the past 8 to 10 years, an active rehabilitative service for the elderly employing a full complement of rehabilitative service personnel—physical therapy, occupational therapy, speech therapy, recreational therapy, nursing service—in a hospital environment—all supervised by a hospital-based group of internists which cares for the patients during their hospital course. The experience accrued from this program I believe supports the following:

(a) Destruction of a valuable capital resource such as this old (1901) tuberculosis hospital is poor stewardship of funds if a quality use for it can be identified.

(b) Responses from our patients and referral sources indicate this service has met a real need in the community.

(c) This need is further supported by the increasing demands for service which has resulted in an occupancy rate of 95 percent in 125 beds and a continual waiting list of 40 to 50 patients.

(d) The medical and rehabilitative needs of this geriatric population can be consistently delivered in a quality manner at about 50 percent of the local acute-care hospital per diem costs.

(e) The medical needs of this multiproblem geriatric patient demand special insights of physician and other health personnel not readily developed by training resources in the area. This has consistently required careful choice of physicians and other personnel and considerable on-the-job training to achieve the approach desired.

The background experience and the insight developed in regard to the critical elements required in this type of geriatric medical care has led this facility into close cooperation with the Joint Commission on Accreditation of Hospitals Quality Resource Center (for which the writer is on the faculty and advisory board) and CEMPROC, the local PSRO, to develop the unusual criteria necessary to identify admission needs and care patterns for the population in such a medically oriented rehabilitation environment. Since this background experience and the data developed in this project at Mount St. Rose Hospital seems worthy of appropriate exploitation to me, I offer any assistance this may give you in deliberations to secure the best and most cost-effective care for our elderly patients.

(2) The perceived needs of the community, the high occupancy and waiting list, and an interest in delivering these services in a cost efficient manner has precipitated a planning program for expansion at Mount St. Rose Hospital. This is fully defined in the enclosure,[1] but centers upon an interest to develop a day-hospital which is projected to cost 50 percent of our present in-patient costs. Active efforts are now in process to bring this to fruition.

(3) The medical personnel supervising this program at Mount St. Rose Hospital are all actively engaged in teaching at St. Louis University. Certain chosen members of the medical house staff have been utilized for service during the past 6 to 8 years. It has been the experience that usually 2 to 3 months of on-the-job training and supervision is necessary for new personnel to appropriately and cost-effectively manage the needs of these geriatric patients.

The potential value of this program for demonstration and teaching geriatric medicine seems obvious. Appropriate support for this with teaching dollars rather than care dollars would allow this geriatric resource to develop a role in training of medical personnel without falsely raising cost of care to do the job.

Considering the increasing age of our population in the United States, a commitment to expanded clinical knowledge of geriatric medical care is an identified need and should be an appropriate activity of internal medicine departments in our schools of medicine. This need is notwithstanding that of efforts directed at broadening our understanding of the aging process through well-founded research. The feasibility and costs of such teaching support seems worth exploration and the model available here could be of invaluable help in defining the necessary parameters for wider application.

If you should so wish, I would be most willing to expand on any of the above material personally or by letter. I thank you for your consideration and interest in geriatric care.

Sincerely yours,

R. WILLIAM BURMEISTER.

[1] Retained in committee files.

ITEM 6. LETTER FROM WILLIAM REICHEL, M.D., PROJECT DIRECTOR, AMERICAN GERIATRICS SOCIETY, INC., NEW YORK, N.Y.; TO SENATOR CHARLES H. PERCY, DATED NOVEMBER 23, 1976

DEAR SENATOR PERCY: Thank you for your letter of November 8, 1976, which contained your opening statement for the hearing on "Medicine and Aging: An Assessment of Opportunities and Neglect." I appreciate your inviting the American Geriatrics Society to submit a written statement for the hearing record describing the recent activities of the American Geriatrics Society Conferences on Geriatric Education which focus upon educational policy and geriatrics.

The American Geriatrics Society was awarded a contract in 1976 by the National Institutes on Aging (NIA Contract No. 263–76–C–0496) for the purpose of conducting two conferences on geriatric education. The first conference took place on October 22–23, 1976. Participants at the first meeting served as an advisory committee for the purpose of developing alternative approaches and models in geriatric education. These approaches and models were to be defined and crystallized for the purpose of presentation to representatives of major physician organizations at the second conference to be conducted on March 4–5, 1977.

The list of members of the Advisory Committee to the American Geriatrics Society Conferences on Geriatric Education is enclosed.[1]

RECENT DEVELOPMENTS AND BACKGROUND INFORMATION

Recent developments which have led up to this meeting include resolution 16 which was introduced to the American Medical Association House of Delegates at the Portland, Ore., meeting in 1974. Resolution 16 called for an increased effort to train physicians in geriatrics. Specifically, it called for incorporating geriatrics into residency programs in family practice, internal medicine, and psychiatry, and into continuing medical education curriculum at both State and National levels. This was adopted by the AMA House of Delegates in June 1975 as Report M, Adequate Training in Geriatric Medicine (A–75). The report indicated that "The Council on Medical Education, together with the AMA Committee on Aging, will continue to review the activities of AMA and other organizations in the field of geriatric medicine. Both committees will explore ways of encouraging the teaching of geriatric medicine in medical schools, residency programs, and postgraduate education, so that appropriate training is available to all physicians responsible for the care of the Nation's elder citizens."

On July 31, 1976, representatives of the American Geriatrics Society (Dr. William Reichel), the Gerontological Society (Dr. Eugene J. Towbin), and the National Institute on Aging (Dr. Robert Butler) met with the Advisory Committee on Undergraduate Education of the AMA Council on Medical Education. At the July 31 meeting, it was the feeling of the three representatives that the subject of geriatric medicine should be included in the curriculum of all American medical schools. Also, the chairman of the Advisory Committee on Undergraduate Medical Education, Dr. Robert Stone, indicated his interest in participating at the two forthcoming American Geriatrics Society Conferences on Geriatric Education.

At the October 22–23 meeting, the advisory committee clarified three models of geriatric education—A, B, and C. The A model comprises an increased emphasis on geriatrics in existing residency programs, such as family practice, internal medicine, and psychiatry, and the B model consists of a 1- to 2-year specialized period in certain residencies, such as internal medicine and psychiatry. This type of subspecialty program is being carried out by Leslie Libow in New York and Dodda Rao in Oak Forest, Ill. Model C is a full, board-certified specialty of geriatric medicine as typified by the British experience.

It was the consensus of the group that model C should be rejected. All of the group felt that this would be an important step in clarifying that there is no attempt to create another board-certified specialty. This might relieve certain anxieties and misunderstandings that might develop from the possibility of another full fledged specialty.

Dr. Libow commented that model B is necessary in order to develop leaders in the field and his program is attempting to do exactly that. Dr. Pfeiffer noted

[1] Retained in committee files.

that at Duke University, the fourth year fellowship in geriatric psychiatry exists. Both Dr. Libow and Pfeiffer expressed the need for trained subspecialists in geriatrics in order to teach residents in internal medicine, family practice, and psychiatry.

Dr. Pfeiffer indicated that a possible strategy would be to support geriatric faculty development in internal medicine, psychiatry, and family practice programs.

Dr. Reichel summarized some of the efforts of family practice residency programs which include geriatrics in their training (model A). These include University of Texas at Lubbock; University of Wisconsin; Medical College of Georgia; Duke University; University of Maryland; University of Iowa; University of Minnesota; Franklin Square Hospital; and St. Margaret's Hospital in Pittsburgh.

Dr. Gotterer, dean of predoctoral programs at Johns Hopkins, suggested that the group must have a clear definition of educational objectives, whether they be to sensitize family physicians to geriatric issues, or to develop a specialist teacher in geriatric medicine. Different models of curriculum for the undergraduate student were discussed. One type of model might be a core knowledge of basic facts about geriatrics; another model might be a more intensive curriculum taught by a research faculty.

A positive approach for effecting change in medical schools utilized by the American Geriatrics Society is to emphasize that aging is already being taught and that this teaching can be expanded upon—in other words, to form a matrix between a geriatric interest with an already established core curriculum. Examples of utilization of already established programs include the curriculum utilized at the New Jersey College of Medicine and Dentistry under Dr. Otto Neurath, or the developing group of faculty who have participated in the Maryland continuing education series of the American Geriatrics Society and Franklin Square Hospital of Baltimore. The same group has contributed to the American Geriatrics publication, *Clinical Aspects of Aging*, and the recent *Hospital Practice* series, "The Geriatric Patient." In these cases, sophisticated faculty were asked to develop a lecture or chapter which represented a matrix between their own existing area of interest and geriatrics. This approach utilizes the best in any given medical community, making use of already existing expertise and talent.

It was the consensus of the conference on geriatric education that research leaders are needed to back up clinicians, residents, and students with their knowledge. However, the research or investigative model for the support of geriatric education is not the only one available. In fact, there is a possibility that in pursuing the research route to stimulate geriatrics, that clinical geriatrics might be lost.

In many situations, it may be desirable to bridge or marry the research components and the service and humanistic components of geriatric education. However, there are clinical areas, such as in family practice, where it may not be necessary to utilize a research-oriented faculty in training programs. The trainee in family practice does not necessarily need to be exposed to research developments in geriatrics and gerontology. However, trainees in medical school or residencies in internal medicine, psychiatry and family practice might very well benefit from exposure to a research-oriented faculty.

Dr. Stone questioned whether the physician should be involved in all aspects of geriatrics. Could other health professionals assume certain roles necessary in geriatric care? Dr. Leslie Libow asserted that geriatrics goes beyond patient care and involves development of health care delivery systems in the community. Dr. Libow also noted that the physician is in the best position to make this system work. A general discussion of the physician's role in present-day society ensued. Dr. Roy noted that she is not able to know everything about her patient's lives, and for practical reasons, cannot be expected to do so. Dr. Libow countered that the social, psychological, and economic aspects of social medicine have been underemphasized in medical education; medical education has been too disease-oriented. He also discussed the survey of seniors attending eight medical schools asking if they wished they had had more special training in geriatric problems. He received many positive responses to this survey which will appear in an upcoming issue of the *Annals of Internal Medicine*.

Dr. Roy and others discussed the practical situation of private practitioners and the difficulty of making ends meet. Dr. Roy made a special point of the increased time which proper care of the elderly patient requires. She indicated

that we should not overpromise what we can do as physicians in the context of the present day realities of delivering medical care to the elderly.

Dr. Libow noted that health systems agencies (HSA's) and other planning and policy groups do not consult those concerned with geriatrics for a geriatric point of view. To make progress in this area, he suggested that those with a special interest in geriatrics should be consulted to develop effective systems of care.

PLANS FOR MARCH 1977 MEETING

Regarding goals for the March meeting, it was hoped that the representatives of major physician associations would be instructed or informed about geriatric medicine—what currently exists and ideas concerning geriatric education. A second goal would be that those attending the March meeting would go back to their own organizations with positive suggestions for action. It is hoped that the physician organizations would also provide support for addition of training in educational programs according to model A or model B.

The next meeting will take place on Friday, March 4, from 12 noon until 2 p.m.; Saturday, March 5, in Baltimore. Physician groups which are being invited, in addition to the American Geriatrics Society and the Gerontological Society, will include the American Medical Association, American Academy of Family Physicians, Association of American Medical Colleges, American College of Physicians, American Society of Internal Medicine, American College of Cardiology, American Psychiatric Association, and the National Medical Association.

Position papers on a number of subjects will be prepared by members of the advisory committee for the March 4–5 meeting. These one- to two-page papers will include:

Undergraduate geriatric education—Ralph Goldman, M.D.
Graduate Education:
A Model—William Reichel, M.D.
B Model—Leslie Libow, M.D.
Rejection of C Model—William Reichel, M.D.
Postgraduate education—Knight Steel, M.D.
County and State Medical Society Committees on Aging—Shirley Roy, M.D.
Economics of geriatric practice—Shirley Roy, M.D.
Medical director concept—Mr. Herman Gruber.
Faculty development—Eric Pfeiffer, M.D.
Curriculum development—William Reichel, M.D.
Long-term care facilities as training sites—Jerry Solon, Ph.D.

In summary, the first Conference on Geriatric Education has clarified three models of geriatric education—A, B, and C. The consensus of the Advisory Committee of the American Geriatrics Society Conference on Geriatric Education is that we should reject the C model. In the discussion of educational models, it was the feeling of the group that it would be an important step in clarifying the position of this advisory committee that another full board-certified specialty is not being called for. This would allow geriatrics to flourish under the existing specialties—internal medicine, family practice, psychiatry, and others—with increased educational contents incorporated into each training program (model A) or 1- to 2-year specialized period of training in certain residencies (model B).

Hopefully the American Geriatrics Society Conference on Geriatric Education will throw additional light on this important subject. It is the intention that these two meetings will allow all viewpoints to be clearly expressed and heard. The American Geriatrics Society is delighted in the interest of the U.S. Senate Special Committee on Aging. With a sense of concern on the part of the American Geriatrics Society, the Gerontological Society, the American Medical Association, and other major physician organizations, in addition to the activities of the U.S. Senate Special Committee on Aging, it is our hope that solutions will come forth in order to improve the health care of our senior citizens.

Again, thank you for your interest in the recent American Geriatrics Society Conferences on Geriatric Education.

Sincerely yours,

WILLIAM REICHEL.

ITEM 7. LETTER AND ENCLOSURES FROM RAYMOND HARRIS, M.D., CENTER FOR THE STUDY OF AGING, INC., ALBANY, N.Y.; TO WILLIAM E. ORIOL, STAFF DIRECTOR, SENATE SPECIAL COMMITTEE ON AGING, DATED OCTOBER 28, 1976

DEAR MR. ORIOL: As you requested at your Special Senate Committee on Aging hearing on October 13, 1976, at the Gerontological Society convention, I am happy to be invited to submit the following:

As president of the Center for the Study of Aging and a long active physician engaged in the practice, teaching, and research in the field of aging, it is my opinion that the time has come for further expansion of geriatric educational training programs in the medical schools of the United States. I am clinical associate professor of medicine, Albany Medical College; chief of cardiology, subdepartment of cardiovascular medicine, St. Peter's Hospital; former vice president of the Gerontological Society; and the author of "The Management of Geriatric Cardiovascular Disease," and editor of the forthcoming volume, "Guide to Fitness After Fifty." The enclosed curriculum vitae and bibliography testify to my experience in research in aging, cardiovascular disease, and community leadership in the field of aging.

The three enclosed reprints on, "Model for a Graduate Geriatric Program at a University Medical School," "Some Observations on Geriatrics as a Specialty," and "Geriatrics as a Specialty," among my writings are the most pertinent to the question at hand. I wish to include these pertinent reprints into the record, since they do represent a well thought out program indicating the necessity for and the type of geriatric education that is so essential in the medical schools of the United States. I have also been involved in planning for the geriatric centers in the Veterans Administration program, the Chicago Medical School geriatric program, and the University of Arkansas Medical School program.

Thank you for this opportunity and invitation.

Sincerely yours,

RAYMOND HARRIS.

[Enclosures.]

As the urgency for services and programs increases over the next quarter century, geriatrics will become an acceptable, highly developed specialty, and geriatric education in medical schools will expand to match the progress in undergraduate programs in gerontology, providing more qualified physicians fully trained in the diagnosis and care of older people. In turn, subspecialties such as geriatric cardiology, geriatric endocrinology, and geriatric psychology will develop. Such specialties and programs will be more necessary to make best use of monies allocated for the health needs of older people.

Model for a Graduate Geriatric Program at a University Medical School[1]

Raymond Harris, MD[2]

The decade between the first White House Conference on Aging in 1961 and the second in 1971 saw the coming of age for gerontological programs in university undergraduate and graduate departments, particularly in human development, social science, and health sections. Contributing to this growth were the powerful pressures built up by the expanding challenges of aging, the belated recognition by politicians of the political importance of aging voters, and the advocacy measures exerted by senior citizens and their organizations to make more money available for such programs.

During this same period, a similar growth was not experienced in medical schools and other educational facilities concerned with the medical training and education of physicians, nurses, and other members of the paramedical professions concerned with care of the aged. The USA lags behind other countries which have recognized the need and urgency for such training in geriatric and allied fields. This [illegible] recognized by the Clinical Medicine Se[illegible] the Gerontological Society and led to the appointment of a Postgraduate Geriatric Medical Education Committee, which was charged with trying to expand geriatric education facilities in universities and medical schools. An excellent geriatric curriculum model for a short-term training program was recently developed by Rodstein (1973) and this committee.

Interest by Future Physicians

Need for programs in clinical gerontology and geriatrics is beginning to be more widely recognized. A senior premedical student at the Univ. of Colorado recently wrote to me:

> As a senior pre-medical student at the University of Colorado, I am very much interested in exploring the field of gerontology. . . . In the attempt to establish gerontology as a separate subspecialty, I realize the difficulties involved, primarily from the educational standpoint, mainly that very little is understood about the process of aging and that to train physicians in this area would mean concentration in the areas of general medicine and psychiatry. The unappealing aspect of gerontology is that the patients are seemingly unproductive members of society and often have a bitter outlook on today's events. The aged seem to have in common a useless role in a world whose scientific achievements result in the prolongation of life. While older people are continually forming a larger segment of the American population, they must be supplied adequate rehabilitation and medical care. I feel that there will be a great demand for geriatricians in the near future, and I would like to devote much time working in this field if I enter medical school next year. I would be very much interested if you could throw any further insights on the subject of gerontology as well as any existing programs at Albany Medical College, especially at the undergraduate level, as I am not yet in medical school.

1. Presented at a Workshop on Geriatrics: A New Model for the Medical and Dental Schools, annual meeting of Gerontological Society, San Juan, Dec. 21, 1972.

2. Clinical Associate Professor of Medicine, Albany Medical College; Chief, Subdept. of Cardiovascular Medicine, St. Peter's Hospital; President, Center for the Study of Aging, Inc., 196 Shaker Rd., Albany 12211.

Reprint from The Gerontologist, Vol. 15, No. 4, August 1975—Printed in U.S.A.

A senior medical student at Georgetown Univ. School of Medicine expressed similar interest:

> I have decided to do my internship and one or two years of medical residency before pursuing any further training in geriatrics per se. By that time I am hoping that fellowships in geriatrics will be available in this country. If not, then I may pursue my training abroad, e.g., at the University of Glasgow. However, the possibility of receiving early training and guidance in this field, as for example at the Albany Medical Center, appeals to me considerably. In any event, please keep me informed of any progress you make or are informed of about formal training programs in clinical geriatrics in this country and abroad.

This same physician wrote me more recently:

> Now I am a first year resident in Internal Medicine at the Rhode Island Hospital, one of the Brown University affiliated hospitals in Providence, Rhode Island. I am very interested in doing a fellowship in geriatric cardiology if such will be available at the Albany Hospital in July, 1974. My career interests include the practice of general internal medicine and geriatrics, with an emphasis on geriatric cardiology.

These are only a few samples of correspondence received from interested premedical and medical students concerning the lack of programs in geriatrics and clinical gerontology in this country.

There is a need for geriatric consultants thoroughly versed in the diseases of aging patients and the age-related changes which occur in the absence of disease. Such specialists are necessary to identify the gaps in our knowledge about aging, to obtain the clinical and research information concerning the age-related changes in disease and normal old age, and to promote and activate modern preventive and therapeutic measures that keep old people healthy and improve their health when disease intervenes. They are essential to develop the concepts of wellness in old age which can come only from determined efforts by a well-organized, well-informed group of physicians who are intimately and vitally concerned with all the aspects of aging and disease in people who are growing old.

Steps in Planning

(1) *Identification of subject matter.*—Courses in geriatric medicine must systematically identify, organize, integrate, and make available all appropriate information on the aging processes, aging-related disease processes, and other data concerned with the clinical, social, preventive, and remedial aspects of illness and health maintenance in the elderly.

(2) *Profile of the geriatrician.*—The specialist in geriatric medicine should have specialized training in diseases of old age and in the care of the elderly. Other practitioners and specialists can and must help care for the aged. Hopefully, they will become more knowledgeable and wise about the problems of their elderly patients. Very likely, they, too, will have to seek the assistance of the geriatric specialist when problems arise, just as the geriatric specialist will require their services for the care of aged people with special heart, gastrointestinal problems, and so on. The geriatric specialist is expected to know much more about aging and the diseases of the aged then his medical confreres. Although the Royal College of Physicians has recommended that after three to four years of general hospital training, four more years should be devoted to medicine or geriatrics before a doctor can be considered a specialist in geriatrics, one must ask if this lengthy period is still necessary. With the current shortage of physicians, perhaps this period may be shortened by "lifetime learning" (McIntosh, 1974).

(3) *Graduate geriatric education models.*—Models for graduate geriatric education may be modified according to the situation and strategies that must be employed.

In May, 1970, I had occasion to draw up one such model program in clinical gerontology at a university medical school and associated Veterans Administration Hospital in the Southwest (Fig. 1). The geographical situation of this medical school made it a central focal point for state and regional programs in aging. The university medical school had an interesting variety of scholarly and community resources, including the Veterans Administration health facilities, the university hospital, community hospitals, nursing homes, other institutions for the aged, and the state university itself, which also included a

Fig. 1 Organization chart for a Division (Center, Institute, or Department) of Clinical Gerontology.

school of social work. It also had other essential components for an innovative successful gerontological teaching division, including (besides the excellent geographical location) sufficient patients and facilities for treatment, education, and research in aging, undergraduate and graduate students, and, most importantly, a devoted faculty interested in the possibilities of geriatrics and clinical gerontology.

Discussions with the Chief of Staff of the Veterans Hospital, the dean, and the other professors and administrators at both the university medical school and the Veterans Administration readily showed that a program in clinical gerontology, strengthening the teaching faculty by the addition of highly qualified clinical and research-oriented gerontologists and providing additional teaching, research, and patient-care facilities at the university hospital, the Veterans Administration Hospital facilities, and the community institutions, would improve the exposure and education of medical students, house staff, and postgraduate students and area physicians, and allied health personnel and nurses, to comprehensive programs in aging and chronic disease.

If physicians are to become more interested and proficient in caring for the aged, it is important that interns and residents during their training be exposed to the management and treatment of normal and sick elderly patients.

Development of outpatient clinics in the downtown section of the city and other types of comprehensive health centers, including halfway houses and a projected neighborhood health center, and the introduction and extension of home-care programs would offer a variety of new therapeutic and preventive care techniques for the delivery of health services in the community.

The Division of Gerontology would encourage and support fundamental research into the processes of aging, develop new scientific knowledge in the field of aging, and introduce courses in gerontology throughout the university medical school and its affiliated institutions. On the undergraduate level, it would introduce instruction in gerontology into the basic medical science course for medical students during their pre-clinical years and into the regular courses of instruction during the clinical years. On the graduate level, it would be involved in the gerontological training of house staff and postgraduate physicians. Such a center would also implement and develop geriatrics and clinical gerontology as a future subspecialty.

Such a clinical gerontology center can be organized into clinical and basic science branches (Fig. 1), both conducting research, teaching, and education. The clinical branch would, in addition, be concerned with the development and delivery of health services to aging patients, including patient care, supervision, research, and administration. The clinical branch in conjunction with other services at the university medical school could also initiate and direct in-service gerontological training for social service, nurses, volunteers, rehabilitation, and other paramedical personnel involved in aging.

The division would also develop affiliations with extended care facilities, chronic disease hospitals, research centers, nursing homes, and other institutions for the aged where in-service training and practice in geriatrics and clinical gerontology can be developed and taught. A special gerontological-social work committee could be established to supervise and conduct improved community programs such as home care, halfway houses, preventive services, and the other community measures so essential for the delivery of health care for the elderly. Such community programs would involve physicians in the county medical society and other professionals and volunteers in the county health and social services departments, senior citizen centers, United Fund, Red Cross, and other voluntary agencies.

The basic science branch would be primarily concerned with basic investigations in aging and would cooperate with the clinical branch in research with humans. Its focus would be the physiological, nutritional, metabolic, and central nervous system changes with aging, depending upon the interest of the investigators and the other members of the faculty at the medical school. Animal facilities at the university medical school should be available for such basic and clinical research.

Personnel

The development of a Division of Clinical Gerontology (Center, Institute, or Department) at the university medical school should initially require a chief and two associates. The chief should be a properly qualified physician and a recognized authority in gerontological education, training, teaching, and research. He would, in turn, work with the other clinical and basic science associates who would be responsible for the supervision and implementation of the appro-

priate programs within their branches. These associates should also be supported and assisted by appropriate faculty, secretarial, and research assistants to enable them to conduct and implement the programs in aging.

The development of a Division of Gerontology within the Dept. of Medicine at the university medical school would provide the university medical school with a much needed new treatment, education, and research center for aging. Such a Division of Clinical Gerontology, emphasizing the medical, scientific, and social needs of elderly people, will help the medical students and house staff at the university and the practicing physicians in the community to learn more about normal growth processes and human development from birth through senescence. It would also improve the delivery of health care to the old people of the area it serves, conserve their financial and other resources, and promote better understanding among the medical and paramedical professions of the impact of an aging population on health, medicine, social structure, problems of work, retirement, leisure, income, and other socioeconomic problems.

Conclusions and Predictions

As the segment of the population 65 years old and older expands to an estimated 21.5 million by 1975, 25 million by 1980, and 28.2 million by the year 2000 (Harris, 1970), the increased number and proportion of older people in the general population of the USA will establish the aged as a truly strong political force pushing this nation toward a gerontocracy and capable of demanding its "right to health" and more adequate programs and services to improve the length and quality of life. More national organizations, in addition to the Gerontological Society, will become more committed and provide extensive training, programming, and leadership as has the US Veterans Administration with its extensive health system and built-in interest in aging. The American College of Cardiology, which recently established a Committee on Geriatrics, will establish liaison with the Veterans Administration and other concerned groups to correct inequities and problems in providing better health care for the aged. Other organizations not already identified with aging will have to measure up to their societal responsibilities.

There will also be much more research on aging and age-related diseases, hastening the conquest of cancer and heart disease already predicted for the 21st century and extending longevity above the age of 80. Much publicized current advances in medical research and patient care have not yet been proved worthwhile in prolonging life expectancy of a person 30 years old or older. Whereas a 30-year-old in 1900 could expect to live 31.2 more years, in 1972 his life expectancy was only 31.7 more years (McIntosh, 1974).

A variety of model programs in gerontology and clinical geriatrics will also develop, based on centers of specialization on cerebral studies, geriatric cardiovascular research centers, and other areas and perhaps following the model and prototype outlined in this paper. Such centers will at the same time provide spin-off benefits in better community care, geriatric hospital and nursing home care for older people.

I predict that by the 21st century the aged will have either been put out of their misery, or the ravages of aging will have been radically corrected.

Addendum

Since this paper was presented, additional support for geriatric programs in medical schools includes the introduction by Senator Frank Moss of Senate Bill 764, which would provide direct funding of up to six medical schools with up to $500,000 each to support geriatric medical programs, the creation of the National Advisory Council on Geriatric Medical Programs with the help of Dr. T. R. Reiff of the Univ. of North Dakota, and the establishment and funding of several geriatric research and clinical center programs by the Veterans Administration.

References

Harris, R. **The management of geriatric cardiovascular disease.** J. B. Lippincott, Philadelphia, 1970.

McIntosh, H. D. Life expectancy. **American Journal of Cardiology, 1974, 34, 127-128.**

Rodstein, M. A model curriculum for an elective course in geriatrics. **Gerontologist, 1973, 13, 231-235.**

Interdiscipl. Topics Geront., Vol. 5, pp. 50–53 (Karger, Basel/München/New York 1970)

Some Observations on Geriatrics as a Specialty

R. Harris

Albany Medical College, Albany, NY

There is nothing more powerful than an idea whose time has come! I concur with Professor Anderson that Geriatrics' time has arrived and I cannot quarrel seriously with the sum and substance of what he says from his extensive experience in geriatric medicine. There is a need for geriatric consultants who are thoroughly versed in the diseases occurring in aging and in the age-related changes that occur in the absence of disease. At present diverse opinions exist concerning the value of specialists in geriatric medicine. However, time and an aging population are on the side of those, like me, who favor the development of a specialty in geriatrics. I belong to these partizans not because I feel the general practitioner and organ specialist should not treat older people, but because I maintain specialists in geriatrics are necessary to continue to identify the gaps in our knowledge about aging, to obtain the clinical and research information concerning the age – related changes in disease and normal old age, and to promote and activate modern preventive and therapeutic measures to keep old people healthy and to improve their health when disease intervenes. Such specialists are essential to develop the concepts of wellness in old age which can come only from determined efforts by a well organized, well informed group of doctors who are intimately and vitally concerned with all the aspects of aging and disease in people.

What must be done to make geriatric medicine a true specialty-more acceptable and palatable to its peers – the medical establishment of the world? Briefly, let us consider (1) Subject matter, (2) The relation of the geriatric specialist to his confreres, and (3) The education and research activity of the geriatric specialist.

1. Subject matter. Professor ANDERSON defines Geriatrics as 'the branch of general medicine concerned with the clinical, social, preventive and remedial aspects of illness in the elderly'. I am sure he would not object to the insertion of 'health' into this definition, so that Geriatrics may be re-defined as 'the branch of general medicine concerned with the clinical, social, preventive and remedial aspects of illness and the maintenance of health in the elderly.' Bearing this definition in mind, we must then systematically *identify, organize, integrate* and make available all the significant information in a format easily acceptable to the seeker of more knowledge on geriatric medicine. Much work has already been done in this area, but books and other teaching aids have not yet appeared in sufficient numbers to impress our medical brethren on the validity of Geriatrics as a specialty, to show them how much geriatric medicine differs from regular medicine, or to interest them more in geriatric medicine. There is much information currently concealed in the archives of the world medical libraries, but this information is scattered and not unified. At this time the presentation of such information in book form appears most feasible, but lectures, movies, tape recordings, film strips, and programmed instruction should not be overlooked as ways of rendering information on aging more available to the interested physician. This material naturally will include data on aging processes, aging related disease processes and other allied information on the clinical, social, preventive and remedial aspects of health and illness in the elderly.

The codification of such knowledge, wisdom and skill will establish a solid basis for Geriatrics as a specialty. It will not be sufficient merely to present such information to improve the general state of knowledge of geriatric medicine among its practitioners. It will be necessary to elevate the state of wisdom of geriatric medicine and to raise the standards of skills and arts in the management and treatment of older people.

2. Relationship of the geriatric specialist to his medical confreres. Now as to the relationship of the geriatric specialist to his medical confreres, I see no real conflict. As Professor ANDERSON points out, the geriatric specialist has specialized training in diseases of old age and in the care of the elderly. As in other specialties, the existence of a geriatric specialist does not preclude treatment by the general practitioner, the internist, the organ specialist like the cardiologist, gastroenterologist and so forth. They, too, can and must help care for the aged. Hopefully, they will become more knowledgeable and wise about the problems in their elderly patients. Very

likely, they, too, will have to seek the assistance of the geriatric specialist when problems arise, just as the geriatric specialist will require their services for the care of the aged in people with special heart, gastrointestinal problems and so on. The geriatric specialist is expected to know much more about aging and the diseases of the aged than his medical confreres.

3. Education, training and research activities. I will not elaborate on the many aspects of aging that Dr. ANDERSON suggests the geriatric specialist should know and practice. But I believe it is of utmost importance that we discuss the education, training and research activities of the specialist in geriatric medicine. We should identify the profile, the special skills and abilities of this specialist. Dr. ANDERSON mentions the 1964 report of the Royal College of Physicians which recommended 'after three to four years of general hospital training, four more years should be devoted to medicine or geriatrics before a doctor can be considered a specialist in Geriatrics.' Is this lengthy period necessary? With the current shortage of physicians, should not this period of training be shortened by pursuit of what we in the U.S. now call 'lifetime learning?'

And what curriculum should be set up for the education of the would-be specialist in geriatrics? What kind of training should he get? What research activities may be expected from the geriatric specialist? And finally, at what point does the geriatrician become a clinical gerontologist? Should the geriatric specialist and the clinical gerontologist have similar training? This question is important enough to warrant further energetic discussion. From my viewpoint both should have similar training so that they can continue to communicate and understand each other. It is the environment in which they work that will distinguish the geriatrician from the clinical gerontologist. The former will pursue his interest and activities in old age on the battleground of clinical medicine, the hospital and the community. The clinical gerontologist, on the other hand, will tend to withdraw more and more into the academic aspects of aging, and conduct his activities within the cloister of the academic and research institutions. Very likely, at some point, each may sally forth into the other's domain with benefit to both and to the specialty of aging. The profession of geriatric specialist will often merge almost imperceptibly into that of clinical gerontologist. Both have a place in gerontological research centers. Both will undoubtedly work together in teams. Eventually the specialist in geriatric medicine will become a true clinical gerontologist concerned with all aspects of aging. The geriatric specialist with a good

education and a mind disciplined by the logic of reason, characterized by unity and method, and tempered by wide experience and equanimity will be able to choose to remain a geriatrician or to become a clinical gerontologist. After all, as SHAKESPEARE asked, 'What's in a name?'

Author's address: Prof. Dr. RAYMOND HARRIS, Albany Medical College, 706 Madison Avenue, *Albany, NY* (USA).

[From the *Geriatric Times*, August 1970]

GERIATRICS AS A SPECIALTY

There is nothing more powerful than an idea whose time has come! There is a need for geriatric consultants who are thoroughly versed in the diseases of aging patients and in the age-related changes that occur in the absence of disease. At present, diverse opinions exist concerning the value of specialists in geriatric medicine. However, time and an increasing aging population are on the side of those, like me, who favor the development of a specialty in the field of geriatrics.

Specialists in geriatrics are necessary to identify the gaps in our knowledge about aging, to obtain the clinical and research information concerning the age-related changes in disease and normal old age, and to promote and activate modern preventive and therapeutic measures that keep old people healthy and improve their health when disease intervenes. Such specialists are essential to develop the concepts of wellness in old age which can come only from determined efforts by a well organized, well informed group of doctors who are intimately and vitally concerned with all the aspects of aging and disease in people who are growing old.

What must be done to make geriatric medicine a true specialty more acceptable and palatable to its peers, the medical establishment of the world? Briefly, let us consider (1) subject matter, (2) the relations of the geriatric specialist to his confreres, and (3) the education and research activity of the geriatric specialist.

1. Subject matter. Geriatrics may be defined as "the branch of general medicine concerned with the clinical, social, preventive and remedial aspects of illness and the maintenance of health in the elderly." Bearing this definition in mind, we must then systematically identify, organize, integrate, and make available all the significant information in a format easily acceptable to the seeker of more knowledge on geriatric medicine. There is much information currently concealed in the archives of the world medical libraries, but this information is scattered and not unified. At this time the presentation of such information in book form appears most feasible, but lectures, movies, tape recordings, film strips, and programed instruction should not be overlooked as ways of rendering information on aging more available to the interested physician. This material naturally will include data on aging processes, aging-related disease processes and other allied information on the clinical, social, preventive, and remedial aspects of health and illness in the elderly.

The codification of such knowledge will establish a solid basis for geriatrics as a specialty. But it will not be sufficient merely to present information to improve the general state of knowledge about geriatric medicine among its practitioners. It will be necessary also to elevate the standards of skill, art, and wisdom in the management and treatment of older people.

2. Relationship of the geriatric specialist to his medical confreres. Now as to the relationship of the geriatric specialist to his medical confreres, I see no real conflict. The geriatric specialist has specialized training in diseases of old age and in the care of the elderly. Other practitioners and specialists can and must help care for the aged. Hopefully, they will become more knowledgeable and wise about the problems in their elderly patients. Very likely they, too, will have to seek the assistance of the geriatric specialist when problems arise, just as the geriatric specialist will require their services for the care of the aged people with special heart, gastrointestinal problems, and so on. The geriatric specialist is expected to know much more about aging and the diseases of the aged than his medical confreres.

3. Education, training, and research activities. I believe it is of utmost importance that we discuss the education, training, and research activities of the specialist in geriatric medicine. We should identify the profile, the special skills and abilities of this specialist. The 1964 report of the Royal College of Physicians recommended "after 3 to 4 years of general hospital training, 4 more years should be devoted to medicine or geriatrics before a doctor can be considered a specialist in geriatrics." Is this lengthy period necessary? With the current shortage of physicians, should not this period of training be shortened by pursuit of what we in the United States now call lifetime learning?

And what curriculum should be set up to educate the would-be specialist in geriatrics? What kind of training should he get? What research activities may be expected from the geriatric specialist? And finally, at what point does the geriatrician become a clinical gerontologist? Should the geriatric specialist and

the clinical gerontologist have similar training? This question is important enough to warrant further energetic discussion. From my viewpoint both should have similar training so that they can continue to communicate and understand each other. It is the environment in which they work that will distinguish the geriatrician from the clinical gerontologist.

—RAYMOND HARRIS, M.D., *Albany Medical College, Albany, N.Y.*

ITEM 8. LETTER AND ENCLOSURES FROM THEODORE R. REIFF, M.D., HEAD, DIVISION OF GERIATRIC MEDICINE, UNIVERSITY OF NORTH DAKOTA, GRAND FORKS, N. DAK.; TO SENATOR CHARLES H. PERCY

DEAR SENATOR PERCY: Since my reply of September 30, 1976, a copy of which is enclosed, to your inquiry regarding our geriatric program at the University of North Dakota School of Medicine, I am pleased to let you know that the president of this university has committed some limited funds to help us keep our program in operation for the time being.

There is, however, a need for additional funds and that is why we are hopeful that the efforts of you and your colleagues on the Special Committee on Aging of the U.S. Senate will develop legislation to provide funding for gerontology and geriatric medical education in the medical schools of this country.

Attached is another copy of a position paper adopted by the National Advisory Council on Geriatric Medical Programs, a list of whose founding members is enclosed, endorsing and urging gerontology and geriatric curricula in the medical schools of the United States.

We would hope that S. 1156 to fund geriatric programs in the medical schools will be reintroduced into the next session of the Congress and passed by the Senate with concurrent action on H.R. 7364 by the House of Representatives.

For the interest of you and your committee, enclosed is a copy of a paper, written at the request of the American Medical Association, originally entitled, "Medical Care of the Aged—A National Scandal," but changed by the A.M.A. to, "We're Doing A Third Rate Job for the Aged." In it is expressed some of the deplorable aspects of geriatric medicine in this country.

Finally, some of the proposed solutions to improving medical knowledge and interest in geriatrics are incorporated into the enclosed proposal for a Gerontology and Geriatric Medical Institute of the University of North Dakota, components of which we are attempting to implement.

My colleagues and I are willing to provide you and your committee with all professionally appropriate assistance in improving the health care for older persons.

With continuing admiration for your efforts and highest professional regards.

[Enclosures.]

THE UNIVERSITY OF NORTH DAKOTA,
Grand Forks, September 30, 1976.

Hon. CHARLES H. PERCY,
Special Committee on Aging,
U.S. Senate, Washington, D.C.

DEAR SENATOR PERCY: I have been asked to respond to your recent letter concerning the meeting in New York of the subcommittee of the Senate Committee on Aging that you are to chair during the week of October 14 in conjunction with the Gerontological Society.

I have been informed by Dr. Leslie Libow, chairman of the Clinical Medicine Section of the Gerontological Society, and Dr. Robert Butler, Director of the National Institute on Aging, that your Senate subcommittee meeting will be on Wednesday, October 13, during which time you will be inquiring into efforts of U.S. medical schools in geriatric education for medical students.

In this regard, I have been requested to present the work done by the University of North Dakota and am scheduled to present this material in a panel on Thursday evening, October 14, and on Saturday, October 16, at the Gerontological Society meetings.

I am glad to supply your committee with this information and am enclosing copies of some material describing programs operational and planned at this university. In specific response to your three questions, please be informed that:

(1) Yes! We do have geriatrics taught in our curriculum through the division of geriatric medicine.

(2) Yes! We do have programs in which students can be taught in nursing homes. We are now planning for opportunities for residents and fellow to participate in geriatric medical exposure in nursing homes during their family practice residency and possibly during their internal medicine residency.

(3). Yes! We do have programs which help serve the elderly in other ways and are planning more extensive efforts in conjunction with our senior citizens center, construction of which is underway to be completed within the next 8 months. Please refer to "Operation Re-Ed" in the enclosed material. This is a program to re-educate older persons for vocational and avocational pursuits.

For your interest, enclosed is a copy of a position paper adopted by the National Advisory Council on Geriatric Medical Programs, endorsing and urging inclusion of gerontology and geriatric curricula in the medical schools of the United States. Your committee's endorsement of this paper would be well received and helpful to our efforts.

Please let me know if you would like more information concerning our program. I congratulate you for your interest in this vital but long neglected field.

With highest professional regards.

Sincerely,

THEODORE R. REIFF, M.D.,
Professor of Medicine,
Head, Division of Geriatric Medicine,
Director of Health Education.

[Attachments.]

POSITION PAPER: NATIONAL ADVISORY COUNCIL ON GERIATRIC MEDICAL PROGRAMS

By the end of this century there will be over 25 million people in the United States over the age of 64. Many of these will have multiple and complex interacting illnesses that require much more care per capita than younger patients. This care requires expertly trained physicians.

At the present time the medical input to a good part of the geriatric institutions in this country is quantitatively as well as qualitatively inadequate. This is not to say that there is not involvement by competent and interested physicians, but it is not an overstatement to say it is rarely sufficient.

It is generally acknowledged that the medical care of older people in this country leaves much to be desired. Geriatric medicine is, to a large extent, a neglected area of medical education and allied health professional training.

Geriatric medicine has not received the stature it should have in this country's medical training programs. Understandably, this makes it exceedingly difficult to attract physicians in training to work in this area.

Actually geriatric medicine provides an excellent opportunity for the in-depth study of human disease and for the training of physicians and allied health care personnel.

Steps to provide solutions to the inadequacy of geriatric medical care are urgently needed. Attention should be directed to developing high caliber programs in geriatric medicine that will serve as models of excellence. These programs should be of such caliber as to attract a significant body of medical students, young physicians, and allied health personnel.

Excellence in geriatric medicine, like any other clinical discipline, must rest on a solid scientific foundation. It is essential that training programs in geriatric medicine include fundamental research in the problems of the aged as well as in the process of aging.

A National Institute on Aging has recently been established within the National Institutes of Health. The time is opportune to support the development of programs in geriatric medicine in the medical institutions of this country.

PROPOSAL

The national advisory council on geriatric medical programs encourages the medical schools in the United States to establish interdisciplinary programs in geriatric medicine. These programs should serve as the basis for geriatric educational experience at all levels of education and training for physicians and allied health care professionals.

FOUNDING MEMBERS, NATIONAL ADVISORY COUNCIL ON GERIATRIC MEDICAL PROGRAMS

Robert L. Grissom, M.D., professor of medicine, University of Nebraska College of Medicine, Omaha, Nebr.

Alexander Leaf, M.D., Jackson professor of clinicial medicine, Harvard Medical school, chief of medical services, Massachusetts General Hospital, Boston, Mass.

Russell V. Lee, M.D., Consultant, Palo Alto Clinic, Palto Alto, Calif.

Henry M. Lemon, M.D., professor of medicine, head, section of Oncology, University of Nebraska College of Medicine, Omaha, Nebr.

Abraham Lilienfield, M.D., professor and chairman, Department of Epidemiology, the Johns Hopkins University School of Hygiene & Public Health, Baltimore, Md.

Ephraim Lisansky, M.D., professor of medicine, University of Maryland School of Medicine, Baltimore, Md.

Sherman M. Mellinkoff, M.D., dean, school of medicine, University of California, Los Angeles (UCLA), Los Angeles, Calif.

Theodore R. Reiff, MD., chairman, professor of medicine, head, division of geriatric medicine, director of health education, University of North Dakota School of Medicine, Grand Forks, N. Dak.

Eugene Towbin, M.D., Ph.D., professor of medicine, associate dean, University of Arkansas School of Medicine, Little Rock, Ark.

Irving S. Wright, M.D., professor emeritus of medicine, Cornell University Medical College, New York, N.Y.

A Proposal to Establish Divisions of Gerontology and Geriatric Medicine at Medical Schools in the United States

It is generally acknowledged that the medical care of older human beings in this country leaves much to be desired. As a corollary to the above the area of geriatric medicine is, to a large extent, a very neglected area of medical training.

Actually geriatric medicine provides an excellent environment for the in-depth study of human disease and for the training of physicians and allied medical personnel.

At the present time the medical staffing of a good part of the geriatric hospitals in this country is quantitatively as well as qualitatively inadequate. This is not to say that there is not representation by competent and interested physicians but it is not an overstatement to say they are in a minority.

One of the reasons this sorry state exists is because geriatric medicine has not received the stature it should have in this country's medical training programs. Understandably this makes it exceedingly difficult to attract new and well trained physicians to work in this *area*.

It is our opinion that an attempt at solution of this problem is in order and that attention should be directed to developing high caliber programs in geriatric medicine that will serve as models of excellence. It is hoped that a significant body of medical students and young physicians in training would be attracted to such programs and make possible the development of this important area of medicine as an attractive field for newer well trained physicians to work.

The scientific base of any good geriatric medicine program must rest on a solid foundation of the science of gerontology. There are a few centers of research gerontology in this country, the most notable of which is the Gerontology Research Center of the National Institutes of Health, located in Baltimore, Md. However, the close integration of research gerontology with geriatric medicine has not taken place to sufficient degree. With the explosion of knowledge in molecular biology that has taken place in the last decade and with newer knowledge of the basic physicochemical mechanisms of life, the potential for a fundamental understanding of the aging process is already existent. With this knowledge, intervention to extend the healthy and productive lifetime of human beings becomes possible.

It is our considered opinion that the time is now ripe to forge ahead in one of the greatest enterprises this country could undertake—the support of gerontologic and geriatric medical programs in the medical schools of the nation.

PROPOSAL

That a select number of medical schools in the United States obtain endowments for chairs in gerontology and geriatric medicine which would form the

nucleus of interdisciplinary divisions of gerontology and geriatric medicine. Each of the selected schools should have an endowed chair in gerontology and one in geriatric medicine, both of whose professional occupants would be members of the single division of gerontology and geriatric medicine that would cross all departmental lines.

The professor of gerontology should be a scientist of excellence and the professor of geriatric medicine should be a clinician of excellence, both of whom would be responsible for the development and expansion of the division as well as for the interdigitation of their respective programs with each other and with the existent programs in the rest of the school. Members of the division of gerontology and geriatric medicine would be encouraged to hold appointments in other appropriate departments of the school.

It would be the responsibility of the professors of gerontology and geriatric medicine to develop programs for scientists and physicians at the undergraduate and graduate levels and to develop training programs for allied health professionals such as physician's assistants and nurse practitioners who should play significant roles in the optimal in-patient and ambulatory care of the elderly.

Support of this type and the medical and scientific enthusiasm it would engender would make a significant contribution to the prolongation and betterment of human life.

THEODORE R. REIFF, M.D.,
Chairman, Subcommittee on Geriatric Medical Programs,
Health Action Council of the Maryland Commission on Aging
and the Johns Hopkins University School of Medicine
and School of Hygiene and Public Health.

[From *Prism*, December 1973]

WE'RE DOING A THIRD-RATE JOB FOR THE AGED

(By Theodore R. Reiff, M.D.[1])

In a recent interview in which the high costs of home dialysis and the type of patient eligible for such care were discussed, the director of a renal dialysis unit in a major hospital was quoted as saying, "Rehabilitation is one of our yardsticks of success. Can the patient go back to his previous work? One girl went back to training and jumping horses." He concluded: "We'll put any person on dialysis if he shows a potential for health. But an older person, say he's 75 and looks his age, well . . ."

This attitude regarding the suitability of elderly patients for renal dialysis is only one example of the ways in which many of the elderly are denied the best medical care. Another is the bizarre switch of intent made by government officials in administering medicare.

In an attempt to provide a bare minimum of physician attendance to nursing home patients, U.S. medicare policies initially provided that nursing home patients covered by medicare be seen at least once a month by physicians. When fiscal constraints became the determinants of this policy, the government, and other third-party carriers, interpreted the provision to mean that medicare would provide for only one visit per month by the patient's physician. The reason for this perversion of intent has been the low priority given to the medical needs of geriatric patients.

Although the circumstances and degree are certainly not directly comparable, it may be worth pointing out that the people of Germany were once led to accept financial priorities in making decisions concerning the right to life.

In the 1930's, the Nazis began a program of "euthanasia" in which nonproductive, "senile" Germans were institutionalized and then put to death by medical personnel. Although much of the German populace was unaware of this medical perversion, the philosophical acceptance of this "pragmatic" practice had been very subtly laid by a number of techniques.

In the mid- and late-1930's, a very interesting change was found in some of the arithmetic textbooks used in German primary schools. For example, the usual problem of finding out how many eggs, at 12 marks per dozen, a person could buy with 100 marks was changed; the question became, "How many

[1] Theodore R. Reiff, M.D., was formerly the medical director of a geriatric center and hospital and a biomedical researcher on the faculties of the Johns Hopkins University School of Hygiene and Public Health and the School of Medicine. He is now the director of health education and chief of the Division of Geriatric Medicine at the University of North Dakota School of Medicine.

Aryan couples can be subsidized to have a child for the Third Reich, at 10,000 marks per couple, for the 40,000 marks it costs each year to keep alive in a nursing home one elderly, senile person who cannot be rehabilitated back to useful work and is of no value to the Reich?'

The above examples may be used to point out the very low order of priority given in a materialistic society to the continued existence of "nonproductive" individuals and, in part, explains the general lack of interest in and the neglect of geriatric medical care in our society.

This neglect extends not only to geriatric medical care, but to all areas of aging, including research. Indeed, a number of this country's leading gerontologists have pointed out the general neglect and lack of support for such research.

The Gerontology Research Center of the National Institutes of Health in Baltimore, directed by the world-renowned gerontologist Dr. Nathan W. Shock, considered by many the "father" of gerontologic research in this country, has undergone major cutbacks in funding that have played a strong role in preventing the development of the center to its greatest potential.

The bill passed by Congress last year to establish, within the National Institutes of Health, a National Institute for Aging Research was vetoed by President Richard M. Nixon.

The Baltimore Gerontology Research Center, which is presently under the National Institute of Child Health and Human Development, receives only a miniscule portion of that institute's funds, most of which goes to child health.

One of the nation's leading gerontologists, Dr. Bernard L. Strehler, professor of biology at the University of Southern California, stated at a conference on aging, sponsored by the Center for the Study of Democratic Institutions, that "the amount of money spent in this Nation to uncover the sources of aging and to determine what can be done about it constitutes a scandal of neglect."

Strehler went on to say, "The national commitment to research on this most universal of human afflictions amounts to about $14 million per annum, perhaps less now that biomedical research in this country has been sacrificed to other 'more urgent and meaningful' goals. That is equivalent to about 8 cents per person per year—the price of one candy bar. It is one-hundredth the cost of a moon shot, one twenty-fifth of a fighter bomber, about 3 miles of metropolitan freeway."

The neglect of geriatric medical care and geriatric training for physicians and allied health professionals and the effect of such neglect on the care of elderly human beings in this country is no less scandalous. And it will assume ever increasing quantitative importance because of the growing percentage of aged persons in our society.

In the summer of 1970, this neglect was starkly dramatized when an outbreak of salmonellosis in a Baltimore nursing home involved 107 out of 140 elderly patients and 30 of the nursing personnel. The disease contributed to the death of at least 25 patients.

The investigation of that outbreak was conducted jointly by the city and State health departments, the Baltimore office of the U.S. Food and Drug Administration, and by personnel from the Center for Disease Control of the U.S. Public Health Service, resulting in the reiteration of the need for appropriate public health and sanitary measures by all agencies concerned. The Governor of Maryland appointed a commission to investigate the matter.

The findings of that commission included statements noting that the nursing home in which the tragedy occurred had no major defects. It had been licensed and approved for care for patients, and that, compared to other nursing homes, it was above average in its facilities, cleanliness, and overall operation.

After the tragedy, I was asked to inspect that nursing home and found nothing to contradict the above commentary. But an analysis of the events leading up to the catastrophe made clear that one of the important reasons for the high number of stricken patients and deaths appears to be that, when the initial symptoms and early deaths appeared, insufficient attention was paid to precise diagnosis and eliciting an accurate cause of death.

Unfortunately, this deficiency is not unusual in the treatment of nursing home and other geriatric patients. It is, in fact, quite common in the overwhelming majority of elderly deaths. Somehow, when older people die, there is a general expectation and acceptance of their death, without interest in the mechanisms or inquiry into possible prevention. This attitude is commonplace among both health professionals and laymen, including family and friends of the patient.

FATALISTIC ATTITUDE

If a younger person dies, both physician and family want to know what happened, why it happened, and what could have been done to prevent it. Physicians ask for, and frequently receive, permission to perform a postmortem examination—an indispensible tool for acquiring precision in the inquiry as to cause of mortality and preexisting morbidity.

Frequently, the information gained is helpful in preventing similar deaths, in providing information to families about hereditary illness and about communicable diseases important from a public health point of view.

On the other hand, if an older person dies, there is generally little interest in finding out what happened, not only on the part of the professional, but also the family, both of whom accept the cause of death as being due to "old age," and they show little interest in the mechanism that brought it about.

This is not to say that there is no importance in the emotional and philosophical acceptance of the inevitability of our own mortality, but such acceptance should not include a hopeless and fatalistic attitude regarding any investigation of the reason for death. The goal of such investigation is the improvement in the quality and duration of life for all elderly people, in fact, for all human beings.

I had the opportunity, for a limited time, to investigate the cause of death in patients at a geriatric center and hospital where the average age was about 85. Many of the deaths were of patients in their 90's and even older. One finding of great interest and importance was that the two most important underlying causes of death were malnutrition, with its attendant debility and lowered resistance, and infection related to debility and presumably to the now-well-established decrease in immunocompetence that takes place with aging. It is worth considering, however, that both malnutrition and infection are, in part, preventable and treatable.

Malnutrition in older people is a well-documented problem, and social and community services in various parts of the country have expressed interest in providing better nutrition for elderly people. Services such as group dining rooms for the elderly and meals-on-wheels have been helpful. The dental profession has been aware of the importance of proper dental care and dentures in mastication, the initial alimentary process. However, with few exceptions, there is little known about digestion and absorption of necessary nutrients from the alimentary tract.

But Paul H. Guth, M.D., of the Wadsworth Veterans Administration Hospital in Los Angeles, has shown that there is a decreased absorption of xylose with advancing age, and there have been other studies indicating that not only carbohydrates but other essential nutrients are poorly absorbed in older people.

The classic studies by Dr. Shock and his colleagues at the Gerontology Research Center have shown clearly that age-dependent decreases occur in almost all organ functions; so it should not be surprising that significant decreases in the alimentary absorption of essential nutrients usually take place. But further definition of this phenomenon is necessary so that corrective measures may be taken. Perhaps older people should take food supplements in the form of amino acids and medium-chain triglycerides. We might also consider the possibility of parenteral hyperalimentation in the debilitated elderly.

One of the major tragedies in the care of geriatric patients is that they are often institutionalized because services and resources are inadequate to provide proper care in the patient's own home. In years past our State mental hospitals became warehouses of senescent people for whom there were insufficient services to allow them to stay relatively independent in their own homes.

Then, too, many State mental hospitals during the past decade prided themselves on the degree to which they reduced their geriatric populations by "returning them to their local communities." But in the majority of instances, the patient ended up in a local community nursing home; so the warehousing took place locally rather than on the State level. The truth of the matter is that we have not developed our community health and personal care services for the elderly to the extent needed to prevent unnecessary institutionalization, with its attendant high morbidity and mortality.

OPTIMAL CARE

With few exceptions, we have not developed in our acute-care hospitals the special medical, nursing, and allied health care necessary for optimal treatment of elderly patients. This is especially true in large public hospitals where understaffing and budgetary problems generally lead to neglect of the geriatric patient, who, as we have seen, is on the low end of the priority scale.

The decubitus ulcer that starts in the geriatric patient in the acute-care hospital because of insufficient position changes and the use of improper bedding is often the start of the downhill course to mortality.

It is common practice in many hospitals to "staff" geriatric wards with lower levels of nursing care when, in fact, the geriatric patient can care for few of his own needs, is dependent, and, thus, actually needs a higher level of nursing care. In many instances, the geriatric patient needs a level of dependency care greater than the pediatric patient, especially since the complexity of illnesses and their complications are greater in the geriatric patient. In addition, the margin for correction of therapeutic error and recovery from disease is much lower in the geriatric patient.

It has been pointed out that the medical care of older persons in this country leaves much to be desired. As a corollary to this, the area of geriatric medicine is to a large extent, a very neglected area of medical training.

At present, the medical staffing of a good number of the geriatric medical care institutions in this country is quantitatively, as well as qualitatively, inadequate. This is not to say that they have no competent and interested physicians, but it is not an overstatement to say that they are in a minority.

One of the reasons for this sorry state is that geriatric medicine is not accorded the stature it should have in this country's medical training programs. Understandably, this makes it exceedingly difficult to attract new and well-trained physicians to work in this area.

Actually, geriatric medicine provides an excellent environment for the in-depth study of human disease and for the training of physicians and other health personnel. We need to turn our attention to the development of high-caliber programs in geriatric medicine that can serve as models of excellence to attract medical students and young physicians in training.

Lately, the seeds of geriatric training programs have begun to be sown. A National Advisory Council on Geriatric Medical Programs has been organized to provide information and to stimulate the development of geriatric medical training.

A geriatric medical program has recently been established at a city hospital affiliated with the Mount Sinai School of Medicine in New York City. The program offers fellowships in geriatric medicine under Dr. Leslie Libow. The New Jersey College of Medicine now offers an elective course in gerontology for its undergraduate medical students, and a community hospital in Baltimore has an on-going geriatric training program in its department of family practice under Dr. William Reichel. This year, Harvard University established a commission for the study of aging, chaired by Dr. Alexander Leaf, which, according to Dean Robert H. Ebert, will serve as a steering committee to oversee a university-wide survey of interest and facilities in the broad area of aging. Moreover, several other schools are considering the initiation of geriatric programs.

"HIGHER PRIORITIES"

The Veterans Administration (VA) has expressed interest in improving geriatric medical training and care, but a modest proposal to fund geriatric centers at five different VA hospitals, at a total cost of $3 million, was not carried out because of Federal cutbacks in medical funding and because of the attitude that there are "higher priorities" in the VA system. It is hoped that the VA proposal will be revived.

Another possible source of support for these needed programs is bill S. 764, proposed by Senator Frank Moss of Utah, which provides for the funding of up to six medical schools with a maximum of $500,000 each for the development of physician training programs in geriatrics. A number of medical schools have expressed keen interest in developing interdisciplinary programs in geriatrics, and there is an urgent need for professional and lay support to encourage the passage of S. 764.

Someone once said that people can be judged by how they treat their pets. Moreover, Federal regulations for the care of laboratory animals are far more stringent and "humane" than are current State and Federal regulations for the care of geriatric patients in our nursing homes. Let us hope that, through support of improved geriatric medical training and care, we will not be afraid to judge ourselves by how we treat our elderly ill.

Appendix 3

MATERIAL DESCRIBING STUDENT EDUCATION PROGRAM

(By Joseph A. Stewart, assistant director, New York University Medical Center, Office of Urban Health Affairs, and director, Geriatric Services and Research Division; and Linda Libow, program planner, Geriatric Services and Research Division)*

A Model for Medical Student Education in Geriatric Medicine and Gerontology

This presentation will be a descriptive report covering 2 years of pilot work in establishing a training program in geriatrics for medical students at New York University School of Medicine.

New York University Medical Center is located in an area of Manhattan that has a considerable population of persons 60 and older. This age group constitutes 16 percent of the total catchment area population or approximately 7,000 persons.

Two years ago, supported by a series of grants from private foundations, N.Y.U. School of Medicine through its Office of Urban Health Affairs began feasibility studies of a coordinated program of geriatric services and research. Two major programmatic ideas have emerged from these studies: (1) The establishment of a demonstration primary care clinic located in a neighborhood setting in an already existing social service agency; and (2) curriculum pilot studies to lead to a training program in geriatrics for medical students.

THE STUDENT PROFILE

In the first year of the pilot training program (1975) 25 applications were received from first and second year N.Y.U. medical students. After personal interviews with student applicants, 6 students were selected: 2 females (both first year students), and 4 males (2 first year and 2 second year students).

In the second year of the pilot training program (1976) 18 applications were received; 16 from New York University School of Medicine and 2 from Albert Einstein College of Medicine. After student interviews six were again accepted, all first-year students: one female and five males, including one student from Albert Einstein.

All students were offered an $800 stipend. The stipend policy is uniform to all programs offered by the Office of Urban Health Affairs. Students have an opportunity to apply for 20 stipends offered in summer electives such as: Adolescent medicine, infant death syndrome research project, medical education research project, floating hospital well-baby clinic, smoking health education project, and another geriatric project studying the effects of social networks among the elderly on health variables. Therefore we suggest that the notion of stipend as sole motivation for interest in geriatrics becomes severely unreliable considering the wide range of stipended choices available.

There are three major goals to our program:

(1) To interest and expose medical students to the health care needs of the elderly, with special emphasis on clinical needs.

(2) To ascertain and affect the attitudes of medical students regarding the person and care of an older individual.

(3) To emphasize the need for holistic treatment of the older person rather than the organ disease.

*This paper was first presented at the 29th Annual Scientific Meeting of the Gerontological Society in New York City on Oct. 16, 1976, and then at the 26th Annual Southern Conference on Gerontology, Feb. 16–18, 1977, sponsored by the Center for Gerontological Studies and Programs, Division of Continuing Education, University of Florida, Gainesville, Fla.

Our specific objectives are:

(1) To provide physician role models in the field of geriatric medicine.

(2) To establish effective field placements where medical students can observe and work with an interdisciplinary team in a hospital or community under the supervision of a physician/geriatrician.

(3) To provide a learning approach to geriatrics and gerontology which is interdisciplinary.

(4) To increase introductory cognitive learning in geriatric medicine and gerontology.

(5) To develop interpersonal skills of the medical student in relating to, interviewing, and diagnosing the older patient.

(6) To acquaint the student to basic literature in the field.

(7) To encourage the research interests of students in geriatric and gerontological issues by means of a term paper on a subject of their choosing.

There are five major components to our training efforts:

(1) The lecture/seminar series.

(2) The field placement.

(3) The interpersonal skill laboratory.

(4) The evaluation/feedback session.

(5) The independent research paper or project.

The program is a full-time 6-week summer elective which runs Monday through Friday from 9 a.m. to 5 p.m. Each of the 6 weeks is based on the following format:

THE WEEKLY FORMAT FOR THE GERIATRIC SUMMER PROGRAM, NEW YORK UNIVERSITY SCHOOL OF MEDICINE

Session	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Lecture/seminar	Field placement	Field placement	Interpersonal skill laboratory.	Evaluation/feedback session.
Lunch	Luncheon/seminar				Luncheon/seminar.
Afternoon	Lecture/seminar	Field placement	Field placement	Interpersonal skill laboratory.	Independent research project/paper time.
Evening	Independent research project work				

(A) *Lecture/Seminar:* The students have 12, 2-hour lecture/seminar sessions which are based on the following topics:

(1) Who are the elderly? What is geriatric medicine?

(2) Normal aging.

(3) Psychological aspects of aging.

(4) Geriatric psychopharmacology.

(5) Specific geriatric problems.

(6) An approach to dealing with the multiple diseases of the elderly.

(7) An international comparison of geriatric health care.

(8) Geriatric rehabilitation.

(9) Sex and aging.

(10) Death and dying and the older patient.

(11) Medicare/Medicaid.

(12) Forms of long-term care: The nursing home, day care, and home care systems.

(13) Formal and informal support systems for the older person.

(14) Nutrition and aging.

(15) Law and aging.

The format for each lecture/seminar is 1 hour for presentation and 1 hour for questions and discussion.

(B) *Luncheon/Seminar:* This segment of the program provides the students with the opportunity for more informational types of learning and also for follow-up learning to the lecture/seminars; e.g., if students wanted further information about psychological aspects of aging, an additional speaker or the same lecturer can be brought back. Also, these sessions will allow broader issues of geriatric care to be reviewed.

Examples of luncheon seminars are:

(a) The political structure and aging concerns.

(b) The press and aging.

(c) Interesting research projects in aging.

(C) *Field placements:* Each student is placed in a geriatric health care program. We look for the following elements in choosing the field placements.

(1) An interdisciplinary team and approach to the care of the older person.

(2) The quality of the care offered is exemplary.

(3) The placement institution is willing to take and teach the student in the mechanisms of care within the facility, under direct supervision of a geriatrician or a physician director.

(4) The facility agrees to participate in the evaluation of the placement and to assist the student in his/her independent research needs, in the field of geriatrics or gerontology.

Examples of the facilities which have offered good field placements are:

(a) Jewish Institute for Geriatric Care, Long Island Jewish Medical Center, New Hyde Park, N.Y.

(b) Bellevue Hospital Center, Geriatric Unit, New York, N.Y.

(c) St. Joseph's Hospital and Nursing Home, Yonkers, N.Y.

Placements are selected after personal interview with the medical director at the facility. A physician preceptor is assigned to each student. The preceptor is expected to monitor the students learning while in the field placement setting. He/she will also be expected to provide an evaluation of the student and the placement at the conclusion of the 6 weeks. The usage of the physician as preceptor is seen as critical for role modeling. Such modeling has two purposes: (1) To show to students types of physicians active in the field of geriatrics; and (2) To show students how physicians work closely with other professionals in a team setting. The students also evaluate the experience after the completion of the placement.

THE INTERPERSONAL SKILL LABORATORY PROGRAM

The decision to develop a day around interviewing skills came from our first year's experience with the program. We found that the students needed and wanted to learn more about their abilities to interview and in particular to learn about the skills necessary to interview the older person. This component of the program introduces the students, through the use of videotape, to their abilities and weaknesses as an interviewer. Then each student is assisted in analyzing, changing, and developing their strengths in the role of a physician interviewer. This is how the first year of our laboratory program worked:

(1) Each student interviewed two older patients presenting different types of problems at the beginning and end of the program. The older patients were two older male and female actors. Videotapes were made of the interviews and these were used as the basis for the skill building sessions that followed.

(2) The tapes were reviewed and evaluated by the actor/patients, the student himself a peer, the program preceptors, a clinical psychologist from the Department of Psychiatry, and a speech therapist.

(3) Weekly skill building sessions were developed around topics such as:

—Listening.

—Prescription giving.

—Interviewing techniques.

—Cultural differences in the elderly.

(4) The final interview and taping session gave the student an opportunity to see himself/herself in a similar interview situation and evaluate their development in handling the older individual in that situation.

THE EVALUATION/FEEDBACK SESSION

This session held on Friday mornings has three general purposes: (1) to allow the student to discuss and comment on his/her field placement, (2) to react to the cognitive learning in the lecture/seminars, and (3) to allow the students to express their feelings and fears about dealing with the elderly.

The sessions are led by the program's preceptors. At each session the student submits his/her log from the previous week which contains a series of questions about their field placements and completes a one page brief evaluation of the program. The log allows the student to formulate his/her plans for the coming week and reflect on how well they have succeeded in the past week. The 1-page evaluation gives us an immediate synopsis of the students reaction to the seminars and total program during the past week.

THE INDEPENDENT RESEARCH PROGRAM/PAPER

The purpose of this segment is not to produce a serious piece of research. The 6-week time limit precludes this. The purpose is rather to introduce the students to the field of the geriatric literature and allow them to become familiar with the fact that such a body of literature exists. This is important if the student is to make the link between his other clinical studies in the regular curriculum and the geriatric elective.

Students have explored a variety of areas. The following are some of the topics or titles chosen:

(1) "Fromaje: A New Short, Portable Mental Status Questionnaire for Assessment of Organic Brain Syndrome in Elderly Persons."

(2) "A Survey of 25 Geriatric HIP Fracture Patients."

(3) "Special Considerations Regarding the Medical Interview and Physical Examination of the Elderly Patient."

(4) "The Formation of Senescent Cataracts and Their Effects on the Aged Patient."

(5) "Drugs and the Elderly."

(6) "The Practice of Polypharmacy in Geriatrics."

(7) "Prognostic Factors in the Rehabilitation of Visually Impaired Older Persons."

TYPES OF LEARNING

In summary then, the total program incorporates three types of learning:

—*Academic:* Through the presentation of material on geriatrics and gerontology in the seminar/lectures.

—*Imitative:* Through the students contact with physician role models in their field placements and in the lecture/seminars.

—*Affective:* From their experiences and learning, we hope that the attitudes and feelings of the medical student have changed, developed, and improved in their approach and caring for the older individual.

As we indicated in the beginning we are not prepared to present experimental findings at this time. We have recently been funded by the Administration on the Aging to formalize our pilot work into a systematized and experimentally evaluated training program this coming summer. We are prepared, however, to provide some overall descriptive program data based on our pilot instruments to date. First of all, an indication of the testing points we used might be helpful.

Demographic form.
Kogan OP scale.
Field placement log.
Weekly review.
Interview evaluation session, student form.
Interview evaluation session, faculty form.
Interview evaluation session, par rating form.
Field placement evaluation.
Supervisors field placement evaluation.
Final evaluation.
Followup questionnaire (4 months later).

In a preliminary look at the evaluation materials the following points can be made: In answer to the question "What did you like most about the geriatric summer program?" the field placements, the Friday feedback/evaluation, and the lectures ranked high with both the 1975 and 1976 students.

In addition, all of the 1976 students liked the interpersonal skill laboratory. (It was only presented in the 1976 pilot program).

Other areas of high ratings related to the student's affective reactions and experiences such as:

(1) The opportunity to examine and work on the patient/physician relationship and specifically related to the older person.

(2) The holistic approach of the training program.

(3) Learning in small groups.

(4) Opportunity to discuss learning experiences openly with professor and students.

(5) Patient contact.

The areas the students felt should be modified or changed included: Limiting of lecture time on Mondays; and more group symposiums on matters such as polypharmacy problems and the role of the drug companies.

Some data was contradictory. The first year's group felt the field trips should be dropped and the second wanted the field trip experience added to the program.

The areas that the students felt needed to be dropped varied each year and focused on visits or field placements which they did not like as opposed to program thrust and content.

In summary, it is suggested that a workable model of preclinical geriatric instruction is possible provided the designer adequately deals with the following points:

(1) Clear clinical relevance of material presented.

(2) Contact with physician models who are actually working in geriatric medicine.

(3) Supervised patient contact on appropriate level of student understanding.

(4) Curriculum mechanisms to tap on-going progress and/or regress of student learning.

Appendix 4

ANNOUNCEMENTS RELATED TO GERIATRIC TRAINING IN MEDICINE

ITEM 1. ARTICLES FROM THE AMERICAN GERIATRICS SOCIETY NEWSLETTER, FEBRUARY 1977

Professorial Chair in Geriatrics Established at Cornell

The New York Hospital-Cornell Medical Center has announced the establishment of a professionship in geriatrics to be known as the Irving Sherwood Wright Professorship in Geriatrics, Dr. Wright, a renowned specialist in vascular disease and professor emeritus at Cornell University Medical College is a past president of the American Geriatrics Society and the recipient of two of the society's gold medal awards, the Edward Henderson Lecture Award and the Thewlis Award. A search committee is being formed to choose the first holder of the new professorship.

This professorship, believed to be the first endowed chair in geriatric medicine in the United States, is made possible by a gift of $1 million from the Gladys and Roland Harriman Foundation. The Wright professorship is expected, the foundation states, "to meet one of the most important needs of the times: the development, analysis, study, teaching, and dissemination of knowledge relating to aging and the application of that knowledge in the prevention and treatment of the illnesses, disabilities, and diseases of the elderly members of society." It is stipulated that "the professorship will be associated with both teaching and research at Cornell University Medical College and with patient care at the New York Hospital, so that both institutions and the people whom they serve will benefit."

AGS Conference on Geriatric Education

The American Geriatrics Society was awarded a contract in 1976 by the National Institute on Aging (NIA Contract No. 263–76–C–0496) for the purpose of conducting two conferences on geriatric education. The first meeting took place on October 22–23, 1976. Participants at the first meeting served as an advisory committee for the purpose of developing alternative models of geriatric education. These approaches and models were to be defined and crystallized for the purpose of presentation to representatives of major physician organizations at the second conference to be conducted on March 4–5, 1977.

There have been many inquiries from those involved in geriatric medicine and geriatric education concerning this meeting. Actually, the purpose of the meeting is not to convene those already in the practice of geriatrics, but rather to have a dialog with leaders and representatives of major physician organizations. The conference is relatively small with only 17 participants at the October session, and approximately 34 participants will attend the second conference.

At the October 22–23 meeting, the advisory committee clarified three models of geriatric education—A, B, and C. The A model comprises an increased emphasis on geriatrics in existing residency programs, such as family practice, internal medicine, and psychiatry, and the B model consists of a 1- to 2-year specialized period in certain residencies, such as internal medicine and psychiatry. This type of subspecialty program is being carried out by Dr. Leslie Libow in New York and Dr. Dodda Rao in Oak Forest, Ill. Model C is a full board-certified specialty of geriatric medicine, apart from internal medicine, family practice, or psychiatry.

It was the consensus of the advisory committee that model C should be rejected. The group felt this would be an important step in demonstrating that

there is no attempt to create another full-fledged, board-certified specialty. Instead, the group supported examples of model A type of program calling for increased emphasis on geriatrics throughout certain specialty training programs, and the model B type program consisting of a 1- to 2-year specialized period in certain residencies. For example, the internist, with an additional 1- to 2-year specialized training, would in a sense be a medical subspecialist in geriatrics. The psychiatrist with an additional 1- to 2-year residency or fellowship would be a geropsychiatrist.

The above stated concepts reflected the thinking of the advisory committee at the October meeting. The thoughts represent a starting point in defining workable models for advancing geriatric medical education.

Views of the readership of the newsletter on this subject are welcome. Please send your views to Dr. William Reichel, project director, Conference on Geriatric Education, 9000 Franklin Square Drive, Baltimore, Md. 21237.

ITEM 2. ABSTRACT OF THE GERONTOLOGY PROGRAM OF THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE AND HEALTH SCIENCES

With a grant made possible by the Administration on Aging for fiscal year 1976–77, the Office of the Dean for Academic Affairs is responsible for the administration, conduct, and coordination of a multidisciplinary program in gerontology. This program is designed to introduce and improve educational programs within the George Washington University and its School of Medicine and Health Sciences, and to encourage research and student involvement in the field of aging. The program is based on a commitment to a multidisciplinary effort on the part of several major departments within the school of medicine and health sciences and other schools and departments in the university. It is proposed that the gerontology content and geriatric care activities to be developed will impact the training programs of medical, nurse practitioner physician assistant, social work and allied health students, psychiatric and primary care residents, and students in recreation therapy, sociology, psychology, health care administration, and law. The program objectives call for:

—Introduction of materials in aging in existing curriculum in the School of Medicine and Health Sciences; introduction of health related gerontology content in existing courses in various schools and departments throughout the university including health care administration, sociology, psychology, education, and law;

—Development of new courses, field placements, and clinical experiences in aging that will support training in existing professional and paraprofessional programs such as the paralegal training program in the National Law Center, the nurse practitioner, physician assistant, and psychiatry programs in the School of Medicine and Health Sciences, the clinical psychology program in the department of psychology, the master's program in recreation therapy in the school of education, the graduate programs in health care administration and long-term care in the school of government and business;

—Development of multidisciplinary seminars in gerontology open to faculty, staff, and students interested in aging;

—Identification and stimulation of universitywide faculty interest and involvement in teaching gerontology and in aging research;

—Identification of resources in gerontology in the university and community for the implementation of program objectives.

With the approval of their advisors and the dean for academic affairs, students in the school of medicine and health sciences and in other schools in the university may select courses in gerontology and geriatric care to either explore gerontology as a career option or develop a field of concentration within various disciplines.

The long-range goal of all these activities taken together is to promote this institution's development of a permanent gerontology center in the school of medicine and health sciences committed to the conduct of multidisciplinary educational research, consultation, and service activities.

For further information contact the gerontology program staff: L. Thompson Bowles, M.D., Dean for Academic Affairs; or Nona Boren, M.S.W., Director, the Gerontology Program.

ITEM 3. NORTHWESTERN UNIVERSITY MEDICAL SCHOOL ANNOUNCEMENT OF A NEW DOCTORAL TRAINING PROGRAM IN THE CLINICAL PSYCHOLOGY OF THE LATTER HALF OF LIFE

To: Chairman, Department of Psychology.
From: David Gutmann, Ph. D., Chief, Division of Psychology.

The Division of Psychology of Northwestern University Medical School, in collaboration with the Committee on Human Development of the University of Chicago, is initiating a doctoral program in the clinical psychology of middle and later life. This 5-year program will entail an integrated agenda of formal classwork, doctoral research, and a graded series of intensively supervised clinical experiences with older patients. Participants in the Northwestern program will share course and supervisory experiences with students in the adulthood and aging program of the Committee on Human Development. While the University of Chicago students will seek clinical training to round out their academic curriculum, the Northwestern participants will be primarily trained as clinical psychologists, particularly knowledgeable about functional, dynamic issues in the psychology of middle and later life, and capable of initiating innovative research and treatment programs in this field.

Required course offerings in the Northwestern University Medical School's Division of Psychology will stress basic clinical skills and the current conceptions of individual psychopathology, individual and group psychotherapy, dynamic personality theory, and community mental health practice. The human Development curriculum offered on the University of Chicago campus will give students an orientation to research methods, to sociobehavioral theories, and to the normal (including developmental) psychology of middle and later life. During the first 2 years, their concomitant half-time clinical training will take place on those treatment services of the Institute of Psychiatry, Northwestern University Medical School, that provide psychological services to middle-aged and older patients. There, students will have intensive contact with older patients, particularly those who have sought treatment for the first time in later life. Through case-by-case, intensively supervised exposures to such populations, the students will have an opportunity to study the psychopathologies that result from the social, somatic, and developmental changes of later life. Students will receive at least two full years of such clinical training, one of which would involve a bloc internship. This residency could be sought in any agency, on or off the Chicago campus, that is ready to continue the student's clinical training with older patients.

In these clinical settings, it is further expected that students will have the opportunity to evaluate academic conceptions of later life psychology that have been generated through studies of nonclinical populations, and to use these in developing new and testable conceptions of pathology and cure. Accordingly, the pre-candidacy exam will cover a significant topic, selected by the student, in the psychology of aging; and his doctoral research will be aimed at making a significant contribution to this literature. In sum, the goal of the program is to graduate creative specialists who can help to generate the as yet unformed field—the clinical psychology of the latter half of life—in which they practice.

CORE FACULTY

David L. Gutmann, Chief, Division of Psychology, Department of Psychiatry, Northwestern University Medical School; and Associate Director of the Joint Program in the Clinical Psychology of Later Life. (Cross-cultural research in the comparative psychology of later life.)

Morton A. Lieberman, Professor, Committee on Human Development and Psychiatry, University of Chicago; and Associate Director of the Joint Program in the Clinical Psychology of Later Life. (Research into the effects of environmental change on the aged, and the utilization of formal and informal helping systems in the last half of life.)

Benjamin Boshes, M.D., emeritus Professor of Psychiatry, Northwestern University Medical School. (Research interests in the clinical neurology of later life.)

Bertram A. Cohler, Associate Professor of Human Development, University of Chicago. (Research on the sociology and psychology of the three-generation family; and on the relations between mothers and grandmothers.)

Gunhild Hagestad, Assistant Professor, Committee on Human Development, University of Chicago. (Research on age grading systems, and on parenthood in the middle years.)

Robert L. Kahn, Associate Professor, Committee on Human Development and Department of Psychiatry, University of Chicago. (Research on relationships between depression and memory functions in the aged.)
Salvadore R. Meddi, Professor of Human Development, University of Chicago. (Research on socialization experiences in adulthood.)
Bernice L. Neugarten, Professor of Human Development, University of Chicago. (Long-time Director of the Adult Development and Aging Program at the University of Chicago; widely published in the areas of psychology and sociology of middle age and aging.)
George H. Pollock, M.D., Ph. D., Director, Chicago Institute for Psychoanalysis, and Professor of Psychiatry, Northwestern University Medical School. (Research into mourning and personality development in middle and later life.)
Harold M. Visotsky, M.D., Chairman, Northwestern University Medical School Department of Psychiatry. (Special seminars in geropsychiatry.)

Participants will be selected from the pool of applicants to the clinical psychology program on the basis of demonstrated interest in the clinical psychology of later life, and prior academic performance. Thus, trainees will have to meet the selection criteria for acceptance into the regular degree program of the Division of Psychology, as well as those set by the special program in aging. Interested students should write, with a brief description of their interests, relevant experiences, and academic accomplishment (including GPA and GRE scores) to: Dr. David Gutmann, Chief, Division of Psychology, Northwestern University Medical School, Institute of Psychiatry, 320 East Huron, Room 410–I, Chicago, Ill. 60611.

Promising applicants will be notified as to how they should complete the application process. Final applications are due February 28, 1977.

ITEM 4. LETTER AND ENCLOSURE FROM JOSEPH M. HOLTZMAN, ASSISTANT PROFESSOR, SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE, TO HERMAN B. BROTMAN, CONSULTING GERONTOLOGIST, FALLS CHURCH, VA., DATED MARCH 2, 1977

DEAR MR. BROTMAN: As you requested I am enclosing a brief description of our program for undergraduates at the school of medicine. In addition, I have included a list of specific goals which we developed for the program. We are currently in the process of developing an appropriate set of goals for inclusion in the family practice residency. Undergraduates receive additional exposure to geriatrics/gerontology in their psychiatry clerkship and in an elective sequence offered jointly by health systems research and family practice. I would be delighted to provide you with more detailed material you might request.

The chairman of our Geriatrics Committee has already passed on these materials to Dr. Butler. I would appreciate it if you would pass copies on to Dick Schloss as we discussed. I will be attending the meetings Dr. Butler has arranged later this month and look forward to seeing you again.

Sincerely yours,

JOSEPH M. HOTZMAN.

[Enclosure.]

GERIATRICS/GERONTOLOGY PROGRAM: A BRIEF DESCRIPTION

The Departments of Family Practice and Health Systems Research at Southern Illinois University School of Medicine have cooperated in the development of a program in gerontology for undergraduate medical students. We believe that the SIU School of Medicine is unique in requiring all medical students to participate in the program as part of the family practice hospital clerkship.

The gerontology program occupies 5 half-days (one-half day each week) during the family practice hospital clerkship. During that period, students become familiar with the problems, care, and treatment of patients in the nursing home setting and in the community. They examine and work up patients in a nursing home setting, receive lectures on theories of aging and common clinical problems associated with old age, and become familiar with community resources available to service the aged. They are exposed to both the sick and well elderly through home visits and visits to senior citizens' centers and nutrition sites.

The undergraduate experience in gerontology is one segment of a developing comprehensive program in gerontology at SIU. Other elements include a con-

80-581—77——7

tinuous 3-year experience for family practice residents as a component of their residency training, in-service training of nursing home personnel, and an ongoing program of research and evaluation in gerontology conducted jointly by the departments of health systems research and family practice.

GERIATRICS/GERONTOLOGY UNDERGRADUATE PROGRAM

Purpose.—To enable the student to identify and discuss the physical, psychological, and socioeconomic problems of the elderly person in American society.

Specific Goals

(1) To gain knowledge of the physiology of the aging process.
(2) To gain knowledge and skills in the diagnosis and treatment of clinical problems of the elderly, including the use of medications in this age group.
(3) To gain experience in working with the health care team in the development and application of treatment plans in institutional and community settings.
(4) To gain experience in helping people with chronic or terminal illness.
(5) To gain knowledge and understanding in a cognitive and affective sense, of old age as a phase of growth and development.
(6) To become aware of whole person evaluation and family and social interactions as they affect the individual's health.
(7) To become aware of one's own attitudes and feelings toward aging and the elderly and the effects of these on overall management.
(8) To gain knowledge of the effects of institutional care on individuals.
(9) To explore the issues of community and home care for the elderly.
(10) To be exposed to administrative factors in running an institution for the elderly.
(11) To become aware of socioeconomic and political issues as they affect the older American citizen.

Program

(A) Teaching faculty and resource people:
At present, the teaching faculty consists of: full-time faculty of the Department of Family Practice, SIU, including several M.D. faculty and two behavioral sciences faculty; faculty from the department of medical humanities; and a medical sociologist from the department of health care planning.
There is a central planning and development committee centered out of the department of family practice with representation from each of the above groups and chaired by a family physician. This committee reports to the chairman of the department of family practice.
Contacts have been established with people active in community based programs with whom the students will be involved. At present this includes: Seniorama, a multipurpose senior center which provides counseling, referrals, advocacy, community service programs, home visitors, a nutrition site, a transport service, and a retired senior volunteer program. Also involved will be: a group of residents from a senior citizen's high-rise apartment building; a Project Life sponsored program of home visitors; and other nutrition sites in the community. Students will visit or meet with these groups for discussion, home visits, etc.
Also involved will be the staff of the local nursing home facility from which some activities will be centered. This will include staff from the following areas: nursing, rehabilitation, intake, staff development, activities, and administration.
(B) Learning activities:
During the 6-month family practice ambulatory clerkship each student will spend several sessions involved with the community activities. Hopefully this will reflect a noninstitutional bias to the program.
Each student also spends a 4-week hospital-based family practice clerkship during which time he will spend five afternoons dealing with issues of aging. The setting for four of these afternoons will be a local nursing home facility and the fifth will be community based.
Didactic discussions will include: the physiology of aging; medical problems of the aged from a problem oriented basis, e.g., problems of ambulation, problems of restricted activity, etc.: prescribing for the elderly; psychosocial issues of institutional and home care; physical and psychosocial rehabilitation. Students will have an assigned group of nursing home residents to help illustrate some of the above issues and to act as an experience base.
The community based afternoon will involve discussions with one or several of the resource groups and a final meeting to help summarize and process some of the student's thoughts and feelings about the experience.

Appendix 5

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR PERCY: If there had been time for everyone to speak at the hearing in New York on October 13, 1976, on "Medicine and Aging: An Assessment of Opportunities and Neglect," I would have said:

The following replies were received:

DAVID HALL BROOKS, NEW YORK, N.Y.

A study of geriatrics for medical students and nurses (and allied health professionals) should not be an elective, an option in a permissive type of curriculum, but should be a mandatory feature of the core curriculum of general medical/clinical studies toward the M.D. degree since there is a body of knowledge and an increasingly large need to know.

Just as orthopedics, rehabilitation medicine, neurology, rheumatology (with the essential anatomy and physiology) can all be brought together under the locomotor system and its problems, so can aging and its problems include pediatric, adolescent, adult, and geriatric areas of attention.

In 1943 at Oxford University (United Kingdom) there was an acknowledged need for greater expertise in the handling of pediatric problems (including neonatological) so the necessary stress was made in lectures, rounds, studies, contacts, and seminars preparatory to the inclusion of two out of six questions in each of two medical, two surgical, and two midwifery/obstetrics/gynecological papers in the final examinations.

Even then, 35 years ago, an early clinical introduction to geriatric medicine was effected by visits on a regular, organized basis to the local Poor Law Institution which was pioneering a new approach to long-term and custodial care (Cowley Road Hospital under Dr. Lionel Zelick Cosin). His enthusiasm was sufficient to light the essential spark of student interest in patient care delivery.

The essential inclusion of aging and geriatric problems in the basic medical undergraduate training (as, for example, in North Dakota's medical school) should be sufficiently stimulating to secure inspired candidates for further specialist or subspecialty training in geriatric medicine, greatly needed in the United States and Canada.

GLORIA K. BYRNES, ST. PAUL, MINN.

I agree with Dr. Butler's and Dr. Libow's position regarding the need for the inclusion of a geriatric specialization in medical schools. The emphasis on geriatric education should be placed in family practice education. The health care of the aged should be seen as part of the life cycle and thus emphasized as part of family practice in order to prevent further alienation of the elderly.

Medicare should be revised to include funding for the training of, not only medical students, but other professionals (social workers, nurses) who enter the field of gerontology in the delivery of health care services.

Attention must also be given to broader areas of medicare reform in order to overcome its deficits. Medicare reimbursement must be provided for home support systems rather than concentrating, as now, on in-patient care. Out-patient drug

coverage must be provided as well, since this comprises a large share of the elderly's medical expenses. Hearing aids, glasses, dental work, and ambulance transportation are other critical areas that require medicare funding.

In order to encourage the practice of preventive medicine, routine physical examinations should be provided under medicare.

CAROL CATLIN, CHICAGO, ILL.

Professional educators derive realistic and idealistic philosophical goals from the needs of the community they serve. Professional educators have a commitment to keep abreast of the ever accumulating knowledge of man and his ever-changing environment. The needs of communities have been changing from the concept that health care services were available to those who could afford, to the present belief that health care services are a right. Medicare was an act designed to insure that certain members of the American population received health care services. Suddenly, professional educators are faced with an older population seeking all kinds of health care services.

Providing safe health care services for older people requires special knowledge and skills. As a masters level nursing student, I evolved a philosophy of nursing applicable to the care of older people requiring rehabilitative services; I studied the biological changes of aging and pursued concepts of why we age. Finally, I studied the particular illnesses of aging while I developed new nursing skills and applied my philosophy of nursing providing health services to older residents of nursing homes. I feel there is more to learn to be a safe health care provider for older people.

Professional educators have the opportunity to provide safe health care practices in meeting the ever-changing needs of the community through the development and application of gerontological courses. Professional educators have the opportunity to increase the knowledge of gerontology through research practices.

The practitioner, the nurse, and the physician have the right to demand quality education and the latest knowledge of health care practices. They must demand courses in gerontology for they are the direct providers of health care services; their license is on the line when they serve the community.

R. KEITH COCHRAN, LUBBOCK, TEX.

I echo the timely and insightful comments of Senator Percy regarding the potential use of our health care personnel and facilities and the benefit they can afford to the elderly of our Nation. There is a phase of health care, however, which, I feel, did not receive adequate emphasis in the hearing, though it may have been one step beyond the comments and intentions of the panel of experts that were present in New York. The significance of preventive health care cannot be overemphasized when considering the topic, "Medicine and Aging: An Assessment of Opportunities and Neglect."

My involvement in the field of aging is through a title VII nutrition program for the elderly. The persons with whom I deal in the program are 60 years or older and, for the most part, are relatively active people. Daily, I see how preventive health services could be significantly advantageous, and I feel confident that others working with noninstitutionalized elderly share my perception.

Programs which would enable persons, educationally, relative not only to dispelling of medical myths, but also to making them aware of resources offered by the health care community, could make a tremendous impact on the overall level of health of the elderly in the United States. Additionally, if diseases could be determined and medically treated prior to the time when they produced a debilitating or devastating effect on the body, the implications to the physical as well as the psychological, well health of the elderly, I think, would be innumerable.

As government increasingly responds to the health needs of the elderly, as well as when medical schools and other academic institutions, which are concerned with educating health care service deliverers, begin developing their curriculum with considerations for the elderly client, they must recognize that the need is great for broadly based programs of health education together with pro-

grams designed to det[illegible] and to treat diseases early in their course. The effect of such preventive medicine can only be, if I may borrow from Senator Percy, "to keep our older citizens functioning as fully as possible for as long as possible."

ROBERT C. COMBS, IRVINE, CALIF.

In order for the medical schools to increase their activities in the field of geriatrics (we recognize our obligation to do so), funds would be necessary. I feel it would be unwise to require schools receiving such funds to form departments of geriatrics. Such departments may or may not logically evolve. To mandate their immediate existence would repeat the greatest problem experienced with family practice programs—that is, starting departments without available qualified chairmen or faculty.

It would be better to start with divisions with departments, or originally just programs.

RUTH DAVIDON, SAN FRANCISCO, CALIF.

Probably the most distressing practice to me is the setting up of programs for aging long-term care clients for 1 year and then starting new ones the following year. No program can prove its worth in so short a time either in service or cost.

An example of this type of costly and wasteful way of beginning a program which is being closed down is the senior day care center which provites support to handicapped aging clients to stay home instead of being institutionalized in warehouses distant from home, family, and friends.

SUZANNE R. DAY, ANN ARBOR, MICH.

Far more attention needs to be applied to the assistance of geriatric chronic conditions than our current medicare system permits. In particular, I am concerned that there are such limited possibilities for home health care when evidence is overwhelming that there is a demand for such service. Economic indicators are mounting in support of such care as a mechanism for reducing escalating medical expenses.

When up to 40 percent of those now in nursing homes have not been kept there for medical reasons, we must develop a more rationally graded system for services to more closely match service delivery to actual service demand. Unless we improve the choices available under our Federal funding system, we shall continue to provide incentives for institutional care requiring unnecessary construction of additional beds as the older population continues to rise.

In documentation of the supply-demand gap, and with the hope that the final section of economic policy implications will be useful to your work, I am enclosing a paper[1] prepared last year and forming a background for my continuing research on these issues.

DEBORAH DOWNEY, EUCLID, OHIO

While at this point in time it has become clear that elderly persons have special medical problems, it is also clear that they have special nursing problems which we, as nurses, thoughtfully need to consider and plan to care for. Therefore, future plans need to be made for graduate and undergraduate nursing programs to meet those needs for health delivery.

JAMES W. ELLOR, CHICAGO, ILL.

Over 95 percent of people over the age of 65 are living in the community, and generally responsible for their own medicine.

---

[1] Retained in committee files.

Many adults have poor self-medication habits, but older adults are particularly susceptible to the potentially resulting problem of adverse drug reactions. While people over 65 comprise 10 percent of the population, they consume 25 percent of all prescription drugs. Physiologically, the older person is at greater risk of experiencing adverse effects from his or her medicine.

Studies made during the past 15 years, as well as our experiences with the elderly, point out several common and potentially dangerous self-medication behaviors:

—a lack of knowledge of the name or action of a particular drug;
—a lack of knowledge of how a particular drug is safely and effectively taken;
—a lack of awareness of side effects;
—stretching medicine to make it last longer than it was prescribed for;
—borrowing and lending medicines;
—saving old medicines and tending to self-treat with these;
—taking medicines irregularly;
—mixing different medicines in the same container;
—overusing or inappropriately using nonprescription medicines.

Our concern centers around the resulting adverse medication actions and interactions that prevent the older person from maintaining an optimal level of health.

The seniors' health program has developed a pilot program of drug education in Chicago. Our general objectives have been: (1) to decrease inappropriate or unnecessary drug use among the elderly, and therefore decrease the number of significant adverse reactions to medication; and (2) to address the current values of society toward aging, especially as reflected in the health care system, and to foster nondiscriminatory attitudes in the community. The program includes group health education sessions, individual counseling, and the creative use of the public media.

MARGARET E. FERRY, BEAR CREEK, PA.

Persons living in nursing homes are labeled as "patients," and they are enmeshed in the medical model. In actuality, medical care occupies a very small portion of the day for those who are chronically ill (as opposed to the convalescent from an acute incident). When, and how, are we going to emphasize the home aspect, rather than the nursing, and concentrate on prolonging living rather than extending dying?

What steps are being taken to provide a working description of a good nursing home (again, for the chronically ill). The acute care values of cure are not really applicable when terminally ill people are being cared for. Some homes pride themselves on their low death rate. when in reality they discharge patients to hospitals to die. How do we provide for a "good" death—and what is it? We discuss reducing mortality from this and that disease, but it will still continue to be 100 percent mortality. How do you propose to deal with alleviating the aches and pains of the aged as compared with the seeming preoccupation with more and more esoteric means of intervention in acute episodes? One old lady told me, "I wish the government would get me dentures and a hearing aid. Then I would have enough money to buy food and I could chew it. When my time comes, let them pull the plug on all that machinery in the hospital—and they will save money and I can enjoy my life while I can still function pretty well."

SALLY FOLLETT, WALTHAM, MASS.

In 1941 I wrote a paper on the attitude of doctors—particularly those belonging to medical associations—toward low-cost care for the elderly. There has been some change, but too many old people are still not receiving the kind of good "caring" care they need (aside from the fact that medical care costs too much). Medicare may be intended for older people, but whoever wrote it doesn't know that many old people may need long-term, costly care.

JACQUELINE L. FRASER, GARDEN CITY, N.Y.

I am sorry that your latest survey was not sent to professional nursing schools across the country asking the same three questions.

There is growing concern for the health care needs of the aged on the part of the nursing profession and greater recognition of the importance of including both classroom and clinical experience in the care of the elderly in basic nursing education programs. I am pleased to learn tonight that the American Nurses Association is conducting a study similar to yours among nursing schools. I look forward to its results.

I do hope that the committee will keep in mind that the health problems of the aged—or any other age group, for that matter—require the interdisciplinary collaboration of many health professions. Their problems cannot be solved by one profession alone.

This hearing is emphasizing the need for more attention to the health problems of the elderly in the curriculae of the health professions. Although the need for advanced practitioners in gerontological nursing is certainly substantiated by facts and figures, some of which were in your statement tonight, the ability of health care facilities such as nursing homes, to employ them is greatly impaired by cuts in funding under medicare and medicaid.

The development of programs to prepare highly qualified practitioners of gerontological nursing is one matter. Providing the funding to support their employment in ambulatory programs and in health care institutions for aged, hence the utilization of their skills for the benefit of our elderly, is quite another matter.

I hope your committee will earnestly address this concern.

MICHAEL GILFIX, PALO ALTO, CALIF.

As a lawyer working in the field of law and aging, I am acutely aware of the failure of the professions to adequately address the problems inherent in aging. Other testimony has established the dearth of training in the area of geriatric medicine in our schools of medicine. Similarly, this area of neglect in the law school context has been recognized and is currently being addressed. In fact, the Administration on Aging is currently funding no fewer than three projects under title IV–A of the Older Americans Act that are designed to develop materials for the teaching of courses on legal problems of elders. The medical profession should, in this case, follow the lead of the legal profession and begin to address this apparent need and add geriatric medicine to its teaching curricula.

As the director of Senior Adults Legal Assistance, and a recipient of a training grant from the Administration on Aging, I am acutely aware of the need for a multidisciplinary approach to the problems of aging. For example, courses on legal problems of elders in law schools are incomplete if they do not simultaneously sensitize and alert students to the psychological and physiological problems that elders encounter and that often have direct legal implications. Accordingly, the materials that I am preparing for courses on legal problems of elders include necessary and relevant content on the subjects of aging and psychology, psychiatry, physiology, economics, history, and anthropology.

Courses in schools of medicine on the subject of geriatrics or aging should be similarly multidisciplinary. For example, decisions as to certain types of treatment for elders or the content of medical reports may have direct legal impact in terms of medical and income governmental benefits. They also may have direct impact in the context of a conservatorship or guardianship proceeding.

I, therefore, urge this committee to take all necessary legislative action to effect the inclusion of medical matters relating to aging in the training of doctors, both in the medical school and in post-medical school training. The content of such training should be sensitive to the interrelationships between medical, legal, and physiological factors.

ROSE GOLDFARB, NEW YORK, N.Y.

We must train more doctors to be general practitioners, and to make house calls.

Gerontology should be an accredited course in every medical school.

An older person should not be told "What do you expect at your age," but be helped to relieve his pain. Most important is passage of a national health service bill that will give protection to all age groups. I'm a member of the Gray Panthers, and we have seminars on national health, so I know that it would be the best thing.

LUCILLE D. GRESS, KANSAS CITY, KANS.

It was indeed a privilege to attend the opening session of the annual scientific meeting of the Gerontological Society in New York, October 13, 1976. The hearing of the U.S. Senate Special Committee on Aging on medicine and aging was indeed appropriate for the occasion. On the basis of the invitation extended at the meeting, I am submitting this statement to be included in the report of the hearing. In spite of efforts made to date, it seems to me the need for additional support of educational programs on human development on aging and the interdisciplinary approach is crucial to meeting the continuing and increasing needs of an aging population.

Granted, there is opportunity and need for additional content on geriatrics in the curriculum of medical schools; I submit there is also need for additional content on geriatrics and gerontology in other educational programs for health personnel—i.e., nursing. Moreover, I believe there is need for nursing students to be involved along with other students taking course work related to aging as a part of the educational experience.

Many of the needs of aging persons are multifacited in nature requiring team effort for achievement of goals. Assessing, establishing goals and priorities related to needs of the elderly necessitates input from the various team members, including the aging person and/or his significant other. In my opinion, teamwork will be more effectively carried out by health care personnel who have gained knowledge and understanding of the roles and responsibilities of others during the educational process in the student role.

Best wishes in your continuing endeavors.

ANN MARIE V. GUILLORY, NEW YORK, N.Y.

There is a tremendous need for the consolidation of services for the elderly. Medicare is failing to serve the needs of the elderly. Senior citizen centers are not reaching the socially isolated, and mental health facilities are not prepared to deal with the mental problems which are exclusive to aging.

The failure to adequately serve the health, social, and psychological needs of the elderly is largely due to the fragmentation of services. A change is needed.

JACQUE HEPPLER, BROOMFIELD, COLO.

I feel that one solution to the doctor's absence in long-term care facilities would be to facilitate the employment of specially prepared registered nurses (geriatric nurse practitioners) by third-party pay reimbursement mechanisms. Senator Percy, what is your stand on this?

LISSY F. JARVIK, LOS ANGELES, CALIF.

UCLA School of Medicine is beginning to make a commitment to aging. We are in the process of (1) starting a geriatric psychiatry ward with input from the division of family practice; (2) starting an outpatient geriatric psychiatry clinic; (3) submitting a postdoctoral training grant; (4) submitting a training grant for research in geriatrics; (5) requiring a visit to a nursing home as part

of the freshman medical course "Introduction to Human Behavior"; (6) having a close working relationship with the VA-GRECC centers in the areas; (7) the first geriatric psychiatry ward in the VA system at the Brentwood VAH; and (8) providing an elective in geriatrics for medical students including one under the auspices of the department of biochemistry.

LUCY JOSEPHSON, NEW YORK, N.Y.

All medicines, treatments, etc., for the aging should be free in every State in the Union. This includes crutches, medical needs, and dental care services.

ETHEL KESHNER, NEW YORK, N.Y.

What effort is being made to correct the many abuses of medicare and medicaid of doctors' charging for services not rendered and/or of arranging for a vast array of medical procedures more harmful than helpful to the helpless patient?

SHARON KLIESEN, ATLANTA, GA.

Medication which is prescribed for the elderly should include information about side effects of the medication, as well as precautions about taking it with other medication, especially over-the-counter medications which the older person may overlook as being important. These drugs are often not reported to the physician.

KATIE LOO, SAN FRANCISCO, CALIF.

There is a need to arouse the medical students' interest in gerontology.

M. MACHUDIS, NEW YORK, N.Y.

Much the same as the study of geriatrics medicine is relegated to passing comments, the study, teaching, training, and treatment of the needs of the elderly persons' dental problems is equally neglected.

There is a great emphasis on the needs of the elderly in all aspects of their existence—more today than ever before—but almost no regard is being given to dentistry, and especially to its relation to its interrelation to all the other medical aspects and needs.

There is great need to give careful consideration to the dental needs of the elderly.

EMILY M. MURPHY, NORTH ANDOVER, MASS.

May I suggest that some sort of printed matter of the legal aid program for older Americans, especially wills, be made available to councils on aging for distribution in their areas? The councils are a great source of outreach daily.

President John F. Kennedy's Peace Corps has been one of the world's most unselfish methods of helping mankind all over the world. So in that vein, I suggest a voluntary service for students who are to become the Nation's lawyers, with credits accumulating toward appointments for work in government programs, or even for elective office. Such credits could be added to their résumés, with adequate publicity.

These services could be paid for by grants or even colleges, who always need grants. The service could be done the year after graduation before passing the bar.

Senator Kennedy, thank you for the legal aid program, the senior aid program, title VII food, the hot lunch school program, and the home care services program.

DAVID A. OTTO, COLUMBIA, MO.

"Medicine and Aging: An assessment of Opportunities and Neglect" is an interesting topic for discussion; such topics, however, represent singular grains of sand in a sea of aging. Until such time as our society returns the "older person" to a proper position of respect and until such time as young people understand that age 40 and senility are not commensurate, it is doubtful that many of our aging problems can be readily solved. Should we not consider first, as a nation, the complete modification of formal education in our public school system so as to "gear" the minds of our children to better understand the aging phenomenon and thus produce a new aging value system? A better understanding of the aging phenomenon at all levels of our society will facilitate a more rapid acceptance of solutions to problems of the phenomenon.

MARLENE PATTERSON, PHILADELPHIA, PA.

There is a need for broadening the topic of "medicine and aging" so that recognition is taken of the existence of social and psycho-social factors impacting on health and medical treatment for the elderly. I therefore recommend that testimony be taken from practitioners in social work and social welfare who could address this perspective.

VIMALA PHILIPOSE, DENVER, COLO.

As Dr. Butler commented in his remarks, the attitude of the health professionals should change if the knowledge in geriatrics is to expand. I offered an elective course in geriatric nursing last year and requested many physicians if they could give a lecture on medical problems of the elderly. Not one of them were willing to, except some residents who were willing to say something on the subject. If Dr. Cooper wants financial aid to medical schools, the Federal Government must establish some criteria when they provide this money; i.e., that the money is utilized for geriatric medical education. This applies to nursing schools, also. There is adequate information right now in aging that medical and nursing students can learn.

Preventive medicine is also a neglected area. Dr. Berlinger, dean, Yale School of Medicine, was not only unimpressive, his information was biased and prejudiced. His comments are a sad commentary to the medical profession. If the problems of the elderly are so similar to the young adults, why should only postgraduate students be studying them? His comments were severely provocative.

The dean talked about problems of drinking, smoking, automobile accidents, etc., and said that doctors could not be responsible for these problems. Ironically, he was smoking himself—a poor role model for the layperson.

I agree with Dr. Sherrod—there is already enough information in geriatric medicine to integrate in medical and nursing schools education. Definite'y, we need more research and knowledge in this area.

I agree also with Dr. Libow's comments. The pediatrics field is mandatory in all medical and nursing schools—geriatrics should also be integrated in all schools of medicine and nursing. Human development continues from infancy to senescence.

Senator Percy, I honor your personal integrity very much. It is regrettable that you did not run for the Presidency of the United States. The world would have benefited by your leadership.

JANE PORCINO, STONY BROOK, N.Y.

Funding should be made available to medical schools—especially developing schools with a clinical hospital attached (such as the State University of New York at Stony Brook)—to develop a specialty in geriatrics and gerontology to meet the needs of this growing segment of our population.

The hearing was exciting, offering many challenging ideas.

CATHERINE A. ROCKWOOD, DEKALB, ILL.

There is a crucial need for factual data and thus preparations and distributions of bulletins to the public in regard to the use of medicines, nature of reactions (possible), and the need to report to the physician/nurse questions and concerns.

One example: Aspirins and other salicylates, when given in large doses by doctors in efforts to reduce pains from arthritis, may cause hearing loss, headaches, etc., and danger when used in conjunction with other medicines.

JON H. ROUCH, WARREN, PA.

Many of the traditional State hospitals care, or used to for the past century since Dorothy Dix promoted such; now one-half their patient population is over 65. Many are psychotics of 30-plus years ago now growing old.

At Warren General Hospital, Warren, Pa., we have a $9 million geriatric patient building (500) including the above, but now also organic problems over 65. Excellent facilities, but why should "lunatics" be put out of the way in rurals? Warren, population 15,000, receives patients from 13 northwest counties of Pennsylvania, including Erie (350,000), plus other cities.

How can an almost defunct State hospital, rural, serve urban needs? How do they justify a $9 million geriatric center there?

Thank you, Senator, for your interest in aging.

ANN SCHORR, NEW YORK, N.Y.

We need national health service for everybody—young and old—financed out of general funds.

JEAN SKORONSKI, CHICAGO, ILL.

As a bridge from consideration of the community to that of the elderly in the United States and, in particular, in housing projects, it may be well to consider that the poverty, isolation, and criminal violence lead to youth lifestyles that is difficult for a middle-class adult to imagine. The isolation of youth from elderly is marked in the community. Worse, the relationship of "the gang" to the elderly is that of predator to victim.

Most adverse drug reactions can be prevented; but prevention requires attitudinal changes and this requires an educational program designed specifically for the elderly and accessible to them. Education is of a particular importance since the elderly are particularly susceptible to the advertising media which is geared to sell medications. Of course, for many elderly persons, taking no medication is better than taking a medication which is harmful rather than helpful.

LORRAINE HIATT SNYDER, SOUTH MINNEAPOLIS, MINN.

Those of us involved in multilevel care geriatric centers, serving several hundreds of people in community services and residential and health care, are deeply concerned about the availability of medical directors, trained and experienced in balanced models of aging. That is, models of aging that respond to the physical, psychological, social, and individual/spiritual needs of older persons. We are concerned that attending physicians often are not trained in more recent concepts reflecting the rehabilitative potential of older persons, on alternatives to pharmecological intervention, on treatment involving the family unit, on newer concepts of psychosocial function and elderly. We are concerned that the physician, who sets in motion the entire array of services open to older persons through medicare and medicaid certification often feels that screening is of no value to the very old, that individuals have limited rehabilitative potential, that disability is concomitant with age. Finally, we are concerned that medical services

be included in many of the home delivered services and made part of community residences specially built for older persons.

We request that quality models of service delivery, involving physicians, be communicated; that more physicians be involved in continuing and new educational programs in gerontology; and that, if necessary, new roles for professionals in medical care of older persons be developed.

Although it should not be necessary to develop geriatrics as a special area of medical practice, it may be that such steps are required to elevate this field to the potential that must be realized. Furthermore, it may be that a special field of geriatric practice is necessary before the family practice physician, internist, and specialist bridge the service and informational needs.

JOAN WALSH TRELEASE, NARRAGANSETT, R.I.

I would like to have seen someone represent the American Osteopathic Society. The D.O. is very much involved with family medicine and the new college of osteopathic medicine in Bedderford, Maine, is incorporating geriatric medicine into its curriculum.

MILDRED UMMEL, DAYTON, OHIO

There is a great need for further education in geriatrics. The opening and opinions and observations presented by Dr. Berliner and Dr. Cooper were very disturbing. Dr. Libow's attitude toward aging is refreshing.

Aging needs an advocate such as you. If ever there is a need for a worker in Ohio, I would be most happy to serve in your cause. If ever you are in Dayton, Ohio, please stop in at the nursing home care unit at the Veterans Administration Center. We would be most happy to have you as our guest.

ROBERT E. VESTAL, NASHVILLE, TENN.

As implied by Dr. Sherrod in his statement, there is an important need for both basic and clinical research in geriatric pharmacology. The older, largely anecdotal literature suggesting that drug response differs in the elderly needs to be substantiated by carefully controlled clinical and laboratory studies. At the Gerontology Research Center (GRC) of the National Institute on Aging in Baltimore, basic research in the pharmacoolgy of receptors reveals, for example, that there are fewer adrenergic and glucocorticoid receptors in cells and tissues from aged experimental animals than from younger animals. These findings may help explain differences in response to catecholamines and steroid preparations in the older patient. Recent studies of age differences in drug distribution and elimination serve to emphasize that age is an important variable when studying the pharmacology of drugs in man. Vanderbilt workers have shown this to be true for diazepam (Valium). Clinical research also suggests that drug sensitivity is affected by age. For example, while at the GCR, Dr. Robertson-Tchaho and coworkers demonstrated that older subjects are more sensitive than younger subjects to the effects of alcohol on memory, auditory attention, and reaction time. However, at the same time we showed alcohol metabolism to be unaffected by age. Much of the limited, available literature in geriatric clinical pharmacology comes from abroad where there is more interest in geriatric medicine. In this country we also need more information about drug utilization and adverse drug reactions in extended care facilities. I concur strongly with Dr. Sherrod that we need to communicate to medical students, residents, and practicing physicians ways of improving therapeutics in elderly patients. Hopefully, this can be based in part on firm knowledge of how pharmacokinetics and pharmacodynamics differ in the elderly.

CAROL WICHITA, TUCSON, ARIZ.

Physicians caring for the elderly and aging people today need to realize they are only part of the team—a very important part, but not the total picture. Aging persons today have problems that require preskills of people who will listen to, not just the physical aspects, but listen beyond the physical aspects and offer so-

lutions other than another prescription. By utilizing skills of nurses, social workers, nutritionists, many times the real problems are identified; i.e., the frustration of a relationship, the denial and anger of a terminal illness, or the fixed income with soaring prices.

People today offer a variety of physical symptoms that often go ignored because the physician does not listen, does not have the skills to solve problems other than medical problems, or uses the age-old excuse, "I don't have time."

Medical care in the United States could be upgraded with cost reduced if the practice of medicine was controlled with Federal rules and regulations to check that group of physicians that abuse the citizens of this country with their greed.

The success of health maintenance organizations in our country is testimony for the upgrading of care with lowered cost.

The last issue I would like to address is that of malpractice insurance. When physicians begin to police themselves in accordance with the code of conduct, the inadequate practitioner would be eliminated—therefore reducing and eventually eliminating the hazard to the profession. In this way the malpractice, which is the real problem, would be reduced, bringing the insurance rates into perspective. As with any other issue, it is only a few that abuse a system and give a negative connotation to the whole. Attitudes of society must change regarding aging, and one way to begin is by offering in medical schools curriculum in the area of aging.

A. KURT WEISS, OKLAHOMA CITY, OKLA.

Regardless of whether the training of experts in geriatrics is accomplished primarily by the establishment of new departments, divisions, or sections of geriatrics or whether this is done in already established departments, the necessity of having basic medical science departments in schools for health professionals staffed by at least a few individuals who have a primary interest in gerontology must not be overlooked. Since the first year or two of professional training in medicine and dentistry usually takes place in basic science departments, the task of interesting individual students and teaching all students the rudiments of gerontology must begin at this level. Basic science professors who are hired to teach and do research in other areas of a discipline cannot and will not devote the necessary time to further the discipline of gerontology. It seems mandatory, therefore, that one or more of the faculty members in the basic medical sciences have a primary interest in gerontology; these individuals can serve as resource personnel and/or coordinators for the gerontology program, which will probably cut across departmental lines of all departments in the basic medical sciences.

PEGGY MARCIA ZAKS, DETROIT, MICH.

This hearing was extremely interesting and invigorating. The major task of the Gerontological Society is to broaden participation and to heighten the Nation's consciousness level about aging related problems. In order to achieve such a demanding goal, the society must disseminate information about the aged to a number of professional and nonprofessional organizations. The fact that you, Senator Percy, have taken an interest in the society's purpose, function, and goals is a good move in the right direction of attaining this worthwhile goal. The society truly needs such catalyzing interests in order to illustrate the utility and potential of the society as a whole.

VICKI ZOOT, SKOKIE, ILL.

1. The geriatric nurse practitioner has the potential to greatly improve the care of the geriatric population. The nursing practice acts of the individual States must be changed to give recognition to this practitioner as a primary care giver.

2. The 1974 amendments to the Older Americans Act struck the requirement for a social worker in a medicare-reimbursed long-term care facility. This was a grievous error. Social workers should be required members of all interdisciplinary health teams, and have a particular significant contribution to make in long-term care.